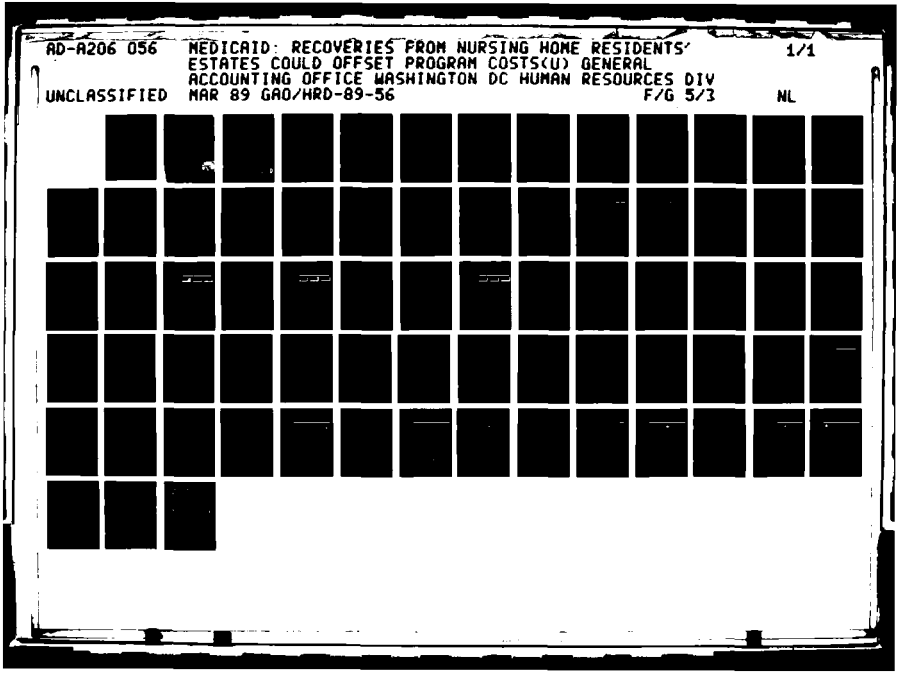
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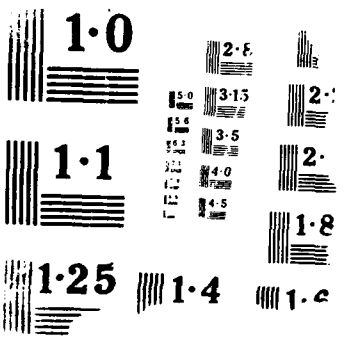
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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226448

March 7, 1989

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

This report discusses the potential for estate recovery programs to help offset state and federal Medicaid nursing home costs while removing an inequity in the program. The inequity involves some nursing home residents with homes having to contribute less toward the cost of their care than recipients with more liquid assets. The report discusses the need for the Congress to consider making mandatory the establishment of estate recovery programs.

Copies of this report are being sent to the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties.

This report was prepared under the direction of Michael Zimmerman, Director, Medicare and Medicaid Issues. Other major contributors are listed in appendix X.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

An increasing proportion of Medicaid funds finance nursing home care for people who become eligible because high medical expenses deplete their financial resources. Such recipients, known as the medically needy, must deplete their available financial resources before turning to Medicaid, but they are generally allowed to keep their homes for as long as they or certain of their dependents need them.

Concerns about the treatment of the recipients' assets have included:

- that the elderly will dispose of their assets for less than their real value in order to become eligible for Medicaid, and
- that the elderly whose assets include a home may not have to contribute as much toward the cost of their care as those whose assets are more liquid.

Such actions cause the taxpayers to shoulder a greater portion of the cost of care than would otherwise be required. These actions also create an inequity between those with and without homes as part of their assets.

The Congress has taken a series of actions to address the first concern, recently requiring states to impose penalties on recipients found to have transferred assets for less than their value within 30 months of applying for Medicaid. Also, states have been authorized, but not required, to establish estate recovery programs to address the second concern.

Through asset recovery programs, states can recover from the estates of nursing home recipients or their survivors a portion of the expenses the state incurs in providing nursing home care. Estate recovery programs require Medicaid recipients whose primary assets are their homes to contribute toward the cost of their nursing home care in the same manner required of recipients whose assets are in the form of stocks, bonds, and cash. Unlike the payments made from liquid assets, however, payments from the home's equity are deferred until the recipient and his or her spouse and dependent children no longer need the home.

GAO studied Medicaid nursing home programs in eight states, focusing particular attention on the estate recovery program operated by Oregon. The objective was to discover the potential financial impact of such programs on Medicaid and whether they provide a mechanism that is acceptable to the elderly for sharing the costs of nursing home care.

Background

The Congress intends that all assets, including home equity, available to Medicaid nursing home residents be used to help pay for their care. However, to lessen the hardship on the family, the home—the primary asset of most elderly Americans—is exempt in determining eligibility as long as there is a spouse, dependent child, or certain other relatives living in the home or the nursing home resident expects to return home.

By restricting transfers of the home and other assets to other than the recipient's spouse and/or placing a lien on a recipient's house, states can help ensure that a Medicaid recipient's assets remain available to defray Medicaid costs. Transfer-of-assets restrictions such as those recently mandated through the Medicare Catastrophic Coverage Act of 1988 apply, however, only while the recipient is alive. Similarly, liens provide only a mechanism for impeding improper transfers. Unless the state also has an estate recovery program, it has no means to recover assets that remain at the time of the recipient's death or, if there is a surviving spouse, at the time of the spouse's death. (See pp. 17 to 19.)

In July 1988 the Department of Health and Human Services' (HHS) Inspector General reported that only 21 states and the District of Columbia had established programs to recover correctly paid benefits from recipients' estates.

Results in Brief

Estate recovery programs provide a cost effective way to offset state and federal costs, while promoting more equitable treatment of Medicaid recipients. Oregon recovers about $10 for every $1 spent administering the program, state officials estimate. Programs such as Oregon's are a logical extension of transfer-of-assets and lien provisions, providing the mechanism for recovering those assets preserved through those measures.

In the eight states studied, as much as two-thirds of the amount spent for nursing home care for Medicaid recipients who owned a home could be recovered from their estates or the estates of their spouses. If implemented carefully, estate recovery programs can achieve savings, while treating the elderly equitably and humanely. Advocacy groups for the elderly in Oregon—the state with the most effective program—told GAO that they had not heard any complaints about the program, and that the state has been flexible in cases where recovery would cause a hardship to the recipient's family.

Principal Findings

Potential Recoveries Are Significant

About 14 percent of the Medicaid nursing home residents in the eight states GAO reviewed owned a home with an average value of about $31,000, based on county records. GAO based this estimate on examination of Medicaid applications filed for random samples of residents admitted to nursing homes during fiscal year 1985 in the eight states. (See pp. 19-20.)

By using home equity to defray Medicaid costs as Oregon does, the six states that now lack recovery programs could recover about $85 million from recipients admitted to nursing homes in fiscal year 1985. This represents 68 percent of the approximately $125 million cost to Medicaid of nursing home care for those recipients who owned homes. (See pp. 20-22.)

In Pennsylvania and Michigan, attempts to establish estate recovery programs through administrative procedures were blocked by legal challenges, state officials told GAO. Oregon avoided such problems by enacting legislation specifically authorizing estate recoveries. (See p. 35.)

Recoveries From Spouses' Estates

Because about one-third of Medicaid nursing home residents who own a home have a spouse living in the community, a significant portion of potential recoveries is lost unless a state authorizes recoveries from the estates of surviving spouses. For example, GAO estimates that California will recover about $15.8 million from the estates of Medicaid recipients admitted to nursing homes in 1985 under its existing recovery program. But it could recover an additional $11 million if the state enacts legislation to authorize recoveries from the estates of the surviving spouse when he or she, in turn, dies. (See pp. 22 and 37.)

Limited HHS Role

HHS, responsible at the federal level for administering the Medicaid program, has little information on effective recovery programs. Moreover, the wording of regulations has contributed to confusion over whether the law permits recoveries from the estates of Medicaid recipients who were under age 65 when they were admitted to a nursing home. As a result, both Oregon and California have limited their recovery programs to recipients 65 or older. (See pp. 23-25.)

Matters for Consideration by the Congress

GAO believes the Congress should consider making mandatory the establishment of programs to recover the cost of Medicaid assistance provided to nursing home residents of all ages either from their estates or from the estates of their surviving spouses. Establishment of such programs would be a logical extension of the transfer-of-assets provisions recently mandated through the Medicare Catastrophic Coverage Act of 1988. Estate recovery programs would help ensure that the assets preserved through the new transfer-of-assets provisions are eventually used to defray state and federal Medicaid costs. (See p. 41.)

Agency Comments

HHS and officials from the seven states that provided comments (California, Michigan, Ohio, Oregon, Pennsylvania, Washington, and Wisconsin) generally agreed that estate recovery programs could offset Medicaid costs. Several state officials identified actions they plan to take to encourage expansion of such programs. (See pp. 41-47.)

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Abbreviations

AARP	American Association of Retired Persons
AFDC	Aid to Families With Dependent Children
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
SSI	Supplemental Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Introduction

A Medicaid applicant's ownership of a home does not usually make him or her ineligible for Medicaid. Even though the home represents a potential resource to the individual that, upon sale or transfer, could be used to defray the costs of medical care, the original Medicaid statute severely limited states' ability to restrict transfers, impose liens, or recover correctly paid benefits from recipients' estates. Specifically, the Social Security Act prohibited states from imposing liens against any recipient's property before his or her death for Medicaid claims correctly paid on the individual's behalf. In effect, the act generally prohibited states from placing restrictions on the applicant's ability to transfer assets for the purpose of establishing Medicaid eligibility.

The law permitted states to recover Medicaid funds from the estates of those recipients aged 65 or over but only after the death of the surviving spouse and only if there was no surviving child under the age of 21 or blind or disabled. Estate recovery programs were hard to administer, however, because of the limits placed on the use of liens and transfer restrictions. States were unable to identify and place liens on property before the recipient's death to ensure that the asset remained for future recovery. This enabled an elderly individual to transfer his or her home to a family member or friend and thereby assure that the home would not be part of his or her estate and, therefore, would not be subject to any recovery action initiated after the death of the individual.

In 1982, the Congress enacted measures to help prevent such practices and ensure that all resources available to an institutionalized individual not needed for support of a spouse or dependent child are applied toward the cost of care. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made it easier for states to restrict transfers, impose liens, and recover the costs of provided services from the estates of Medicaid recipients. This report focuses primarily on estate recovery programs.

Medicaid

Medicaid is a federally aided, state-administered medical assistance program that served about 22 million needy people in fiscal year 1985. It became effective on January 1, 1966, under authority of title XIX of the Social Security Act, as amended (42 U.S.C. 1396). Within broad federal limits, states set the scope and reimbursement rates for medical services offered and make payments directly to the providers who render services.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), has overall responsibility for

administering the Medicaid program at the federal level. This includes developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and policies. The nature and scope of a state's Medicaid program are contained in a state plan, which, after approval by HHS, provides the basis for federal funding.

Medicaid Eligibility Criteria

Medicaid eligibility criteria are among the most complex of all assistance programs. At a minimum, states must provide Medicaid coverage to all persons who receive cash payments from the Aid to Families With Dependent Children (AFDC) program and almost all persons covered by the Supplemental Security Income (SSI) program.[1] These Medicaid recipients are called categorically needy.

At their option, states can extend Medicaid coverage to certain groups, including (1) institutionalized individuals with incomes up to 300 percent of the SSI payment level (42 C.F.R. 435.231) and (2) those who would be eligible for cash assistance if they were not in an institution (42 C.F.R. 435.211).

States also can extend Medicaid coverage to individuals who are ineligible for cash assistance on the basis of income but whose income and resources are considered insufficient to meet their medical needs. Programs for these medically needy persons accommodate individuals who meet all the criteria for categorical assistance except for income and who have incurred relatively large medical bills. Persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses for purposes of determining their countable income to determine eligibility for Medicaid. In fiscal year 1985, 34 states and the District of Columbia had medically needy programs.

In addition to meeting income limits, Medicaid applicants' assets must be within specified limits. For example, to qualify for Medicaid as an SSI recipient in 1988, an applicant could have a home of any value but could not have liquid assets worth more than $1,900 for an individual and

[1] Fourteen states limit Medicaid coverage of SSI recipients by requiring them to meet more restrictive eligibility standards in effect before the January 1, 1972, implementation of SSI, the Congressional Research Service reported in July 1987. States choosing this option must allow applicants to deduct medical expenses from income to establish eligibility. The 14 states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia) are referred to commonly as "209 (b) states."

$2,850 for a couple. Under certain circumstances, states can impose more stringent asset limits for SSI beneficiaries.

Asset limits for medically needy programs vary by state, but must be (1) at least as liberal as the highest limits allowed for cash assistance recipients in the state and (2) the same for all covered groups. The liquid asset limits for a family of two ranged from $2,250 to $6,450 as of the second quarter of 1987.

According to the Congressional Research Service, the majority of elderly persons who become eligible for Medicaid's nursing home benefit do so only after they have spent down to Medicaid income and asset limits. Generally, they enter the nursing home as a private pay patient and convert to Medicaid after having spent their "excess" income and resources on nursing home care.

Middle-income nursing home residents with sizeable assets may find it difficult to qualify for Medicaid. This creates an incentive to transfer or otherwise dispose of assets for less than fair market value in order to establish Medicaid eligibility.

Boren-Long Amendment Limits Transfers

In an attempt to limit the ability of individuals to get around Medicaid asset limits by transferring assets, the Congress passed the Boren-Long Amendment of 1980, which permitted states to restrict transfers of non-exempt assets. This amendment had limited effect, however, because home equity—an exempt asset—represents the primary asset of most elderly. Under the Boren-Long Amendment, a home can be transferred to a son or daughter or other person at any time without affecting Medicaid eligibility.

TEFRA Further Restricts Transfers and Authorizes Greater Use of Liens and Estate Recoveries

To further limit the ability of individuals with assets that could be used to pay for their nursing home care to give those assets away in order to establish Medicaid eligibility, the Congress enacted section 132 of TEFRA. The act modified provisions of the Social Security Act (section 1917) by authorizing states to place further restrictions on asset transfers, thus making it easier to impose liens against the assets. TEFRA also established the conditions under which states can undertake estate recovery. The changes in the lien and transfer-of-assets provisions should enhance states' ability to operate effective programs. HHS noted in its implementing regulations that the TEFRA provisions are

". . . intended to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children, will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance government's legitimate interest in recovering its Medicaid costs against the individual's need to have the home available in the event discharge from the institution becomes feasible."

The original transfer-of-assets provisions of TEFRA permitted states to deny Medicaid assistance to any individual who otherwise became eligible because he or she disposed of resources for less than fair market value within 2 years of applying for Medicaid or at any time after this period. The time period was subsequently extended to 30 months by the Medicare Catastrophic Coverage Act of 1988 (see p. 13). A Medicaid recipient may be declared ineligible if the home, an excludable asset, is transferred for less than fair market value to anyone other than the spouse, child under 21 years of age, or child who is blind or disabled while the recipient is in a nursing home. Transfer-of-assets policies have been adopted by 49 states.

TEFRA allows a state to place a lien against a recipient's real property for the purpose of recovering correctly paid Medicaid benefits if the state can reasonably determine that the recipient is not expected to return home. A state may not place a lien on an individual's home if his or her spouse or dependent child is lawfully residing in the home. In addition, a lien must be removed if the recipient returns home. Liens are not self-executory, but merely impede the ability of the property holder to convey the property. If a lien exists, the property holder must satisfy the lien before the property may be sold or transferred. The lien holder—in this case the state Medicaid agency—does not have to wait until the property is sold or transferred to recover; it can itself force the sale of the property to satisfy its claim. Only Alabama and Maryland intentionally place liens prior to death to recover correctly paid benefits provided to Medicaid nursing home residents, according to the HHS Inspector General's June 1988 report.

Finally, TEFRA established conditions under which states can defray the costs of Medicaid assistance paid on behalf of nursing home residents through estate recovery. Under an estate recovery program, the state files a claim against the estate for the cost of Medicaid assistance provided.[1] As in the prior statutes, recovery cannot be made until (1) the death of the recipient's spouse and (2) the recipient has no surviving

[1]If the estate is not settled in probate court, the state can seek reimbursement from the executor of the estate.

child who is either under 21 or who is blind or disabled. In addition, TEFRA provided that recovery cannot be undertaken based on a lien imposed on the home if certain relatives have resided there since the Medicaid recipient moved into the institution.[1] Despite these limitations, designed to prevent estate recoveries from creating undue hardship on the Medicaid recipient's family, TEFRA enhanced states' abilities to operate effective recovery programs by helping ensure that assets were not disposed of for less than fair market value in order to establish Medicaid eligibility or preserve an inheritance.

According to the HHS Inspector General's June 1988 report, 21 states and the District of Columbia have active estate recovery programs to recover correctly paid benefits. Although they reported annual recoveries totaling about $42 million, the average gross recovery per Medicaid nursing home resident ranged from about $4 in Rhode Island to $327 in Oregon (see table 1.1).

[1]A sibling must have lived in the house for at least 1 year before the recipient entered the nursing home; a son or daughter at least 2 years.

Table 1.1: Annual Medicaid Estate Recoveries

State	Amount of recovery[a]	Cost of recovery	Average gross recovery per Medicaid nursing home resident
Alabama	$202,000	$55,000	$9.74
California	12,000,000	625,600	91.37
Connecticut	2,100,000	250,000	67.55
District of Columbia	300,000	129,408	95.39
Florida[b]	640,941		17.00
Georgia[c]	1,089,358		30.35
Hawaii	68,208	8,280	16.78
Illinois	1,620,000	70,400	22.08
Indiana[d]	400,000		9.86
Maryland	1,230,071	104,000	45.91
Massachusetts	4,800,000	93,450	109.05
Minnesota	4,722,895		100.80
Missouri	453,000	21,391	15.53
Montana	150,000	15,000	29.93
New Hampshire	900,000	66,000	160.11
New Jersey	435,000	150,000	13.51
New York[b]	5,942,995		53.82
North Dakota	316,955	34,200	51.76
Oregon	4,000,000	306,000	327.44
Rhode Island	45,000	26,000	4.24
Utah	230,000	45,000	40.74
Vermont	69,326	5,667	20.34
Total	**$41,715,749**	**$2,005,396**	

Source: Medicaid Estate Recoveries, Office of Inspector General, HHS OAI-09-86-00078, June 1988, p. 27

[a]The Inspector General's report does not state the time frame for reported recoveries except where noted.

[b]Amounts listed as recoveries are those reported to HCFA as "probate recoveries" in federal fiscal year 1985.

[c]Unknown.

[d]Indiana no longer tracks estate recoveries. This figure is a projection based on past recovery performance.

Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988 amended TEFRA provisions pertaining to Medicaid estate recoveries. The act extends (to 30 months) and makes mandatory the restrictions on transfers of assets for less than fair market value. This should help ensure that resources remain available for later recovery. Second, the act makes it easier for a

couple to qualify for Medicaid by requiring states to exclude more income and resources in determining eligibility if there is a noninstitutionalized spouse. Because not as much of a couple's income must be applied toward the cost of care, these provisions will make it easier for middle-income elderly to spend down to qualify for Medicaid and this should increase recovery potential. Finally, the act requires the Secretary of HHS to study the means for recovering the amounts from the estates of deceased beneficiaries (or the estates of spouses of deceased beneficiaries) to pay for nursing home services furnished under Medicaid. The Secretary was required to report to the Congress no later than December 31, 1988, and to include appropriate recommendations for changes.

Objectives, Scope, and Methodology

We performed this review to assess the extent and effectiveness of state efforts to reduce program costs by using the estates of Medicaid nursing home recipients or their surviving spouses to recover all or part of the costs of care paid for by Medicaid. Our specific objectives concerning estate recovery programs were to

- identify key elements of effective programs,
- estimate potential savings from establishment or expansion of programs,
- identify barriers to the establishment of programs, and
- evaluate policy implications of programs.

We chose the Oregon program to identify the key elements of a successful estate recovery program because it reported annual recoveries per nursing home recipient more than twice those reported by any other state. In addition, Oregon has been mentioned by HCFA as a model program. In Oregon, we (1) reviewed pertinent laws, regulations, and procedures supporting the estate recovery program, (2) obtained the views of state officials on the elements of their program that they believed were most important to its success, and (3) obtained the views of representatives of advocacy groups for the elderly, such as the Gray Panthers, the American Association of Retired Persons (AARP), United Seniors, and the Senior Law Center.

To determine the potential for Medicaid cost savings from the establishment or expansion of estate recovery programs, we reviewed the Medicaid applications for 200 randomly selected nursing home residents from Oregon and seven other states. We selected six states (Michigan, Ohio, Pennsylvania, Texas, Washington, and Wisconsin) because they

did not have recovery programs and had among the largest Medicaid nursing home programs. We selected California because it (1) operates an estate recovery program but was recovering significantly less per recipient than Oregon when we began our review and (2) accounts for about 8 percent of all Medicaid nursing home payments.

In each state, we reviewed the Medicaid application (or SSI application if Medicaid eligibility was established based on SSI eligibility) for 200 randomly selected Medicaid recipients 65 years of age or older who were first admitted to nursing homes in calendar year 1985.[1] We selected 1985 as a sampling time frame rather than 1986 or 1987, to enable us to obtain actual Medicaid cost data on as many recipients as possible. Using the applications, we identified recipients who declared real property ownership. In 13 counties in seven states, we reviewed county records at the offices of the county assessors and treasurers to determine whether recipients (1) owned real property that was not declared on their applications or (2) transferred property for less than fair market value within 2 years of or after applying for Medicaid. Because our work in the 13 counties did not identify many instances of home ownership or transfers not disclosed on the applications, we decided to limit our evaluation to home ownership disclosed on the Medicaid and/or SSI application.

For recipients with real property, we contacted the county assessor's or treasurer's office to determine the value of the property. We then estimated potential recoveries from the estates of recipients with real property based on the policies and procedures followed in the Oregon recovery program. Finally, we projected recoveries to the universes for each of the eight states. Our methods for estimating potential recoveries are discussed in more detail in appendix I.

To identify barriers to the establishment or expansion of estate recovery programs, we (1) interviewed Medicaid officials in the eight states; (2) attended a legislative hearing in the state of Washington on proposed estate recovery legislation; (3) interviewed HCFA headquarters and regional office officials to determine HCFA's role in assisting states in establishing recovery programs; and (4) interviewed representatives from AARP, the Gray Panthers, and advocacy groups for the elderly in Oregon about the Oregon program.

[1]We limited our review to recipients 65 or older because HHS, in publishing its implementing regulations, appeared to limit recoveries to that age group.

Our work was done between September 1986 and August 1987 in accordance with generally accepted government auditing standards.

Significant Recovery of Nursing Home Costs From Estates Possible

Many elderly who own a home when they enter a nursing home still own it when they die. States that do not operate effective estate recovery programs lose the opportunity to use this primary asset of about one-fourth of Medicaid recipients—their home equity—to defray Medicaid costs. This is because transfer-of-assets provisions do not apply to assets remaining at the time of the Medicaid recipient's death, and liens are not self-executing.

Of elderly Medicaid recipients admitted to nursing homes during calendar year 1985 in the eight states reviewed, about 14 percent owned a home or other real property (such as a farm) at the time they applied for Medicaid. The average value of the real property they held based on county assessment records was about $31,000. We estimate that although Medicaid will pay an average $12,000 in nursing home bills for those recipients, only about $1,350 of those payments is likely to be recovered because

- six of the eight states had no programs to recover their Medicaid nursing home costs from the estates of Medicaid recipients and their spouses, and
- one state (California) had a recovery program but was not recovering from the estates of surviving spouses.

If the seven states had had programs similar to Oregon's, we estimate that an additional $6,716 on average could have been recovered per recipient.

Another opportunity for recoveries was lost in all eight states because HCFA regulations did not clearly indicate that recoveries were permitted for institutionalized recipients under age 65. We did not estimate potential recoveries for this group, but believe they could be significant based on the extent of home ownership in younger age groups.

States Need Both Transfer-of-Assets and Recovery Programs

Estate recoveries are an essential component of state efforts to ensure that Medicaid recipients' assets are used to defray Medicaid costs. In effect, a state that has a transfer-of-assets policy but no recovery program ensures that the home remains available to defray Medicaid costs while the recipient is alive, but fails to recover upon the death of the recipient, even if there is no surviving spouse. The absence of an estate recovery program also creates inequities in the treatment of Medicaid recipients and their heirs, allowing recipients who still own a home at the time of death to leave an estate, while requiring those that do not

own a home to apply most of their liquid assets toward the cost of their care before they become Medicaid-eligible.

The Congress intended to enable states to require that all of an institutionalized recipient's available resources be used to defray the costs of institutionalization (section 1917, Social Security Act). As we discuss on pages 10-12, such resources include equity in a home. These and certain other resources, however, are not available to help pay for institutional costs while the assets are needed to support a spouse or dependent child or if there is a chance that the recipient will return home. Each of the states we reviewed had established a transfer-of-assets policy to prevent an individual from transferring assets to other than the spouse or dependent child in order to establish Medicaid eligibility. But six of the eight states (Michigan, Ohio, Pennsylvania, Texas, Washington, and Wisconsin) had not, at the time of our review, established an estate recovery program.

Without a recovery program, a transfer-of-assets policy leaves the states without a mechanism to use assets remaining at the time of death to defray Medicaid costs. Also, any such assets revert to the recipient's estate and can be transferred to the recipient's nondependent children or other heirs without first being used to defray Medicaid costs. The following hypothetical example illustrates the inequities that could result.

Example 1—A widow who had been living alone in her $40,000 home enters a nursing home, but expects to return home. The widow's home is exempt in determining Medicaid eligibility. If the woman died after 1 year in the nursing home without selling the home, her heirs would inherit the home and none of the proceeds from its sale would be used to repay the Medicaid program for the $15,000 in nursing home payments. However, if the home had been sold before she died, the widow would be ineligible for Medicaid benefits until the remainder from the sale of the home had been spent down to the $1,500 Medicaid asset limit. In addition, proceeds from the sale could have been used to repay the Medicaid program for the nursing home costs already incurred if the state had placed a lien on her property before she died. The woman's heirs would have received only those funds remaining at the time of death that were not needed to pay for the parent's nursing home care.

Finally, if the widow had $40,000 in savings but did not own a home, she would have been required to spend down to the Medicaid asset limit ($1,500) as a private pay patient before she could become eligible for

Medicaid. After about 2 years as a private pay patient, she could have established Medicaid eligibility. During those 2 years, the Medicaid program would have avoided about $30,000 in nursing home payments. The adult child would be left with no inheritance.

The above example shows that a recipient who does not own a home or sells a home while in a nursing home must apply his or her assets toward the cost of nursing home care. On the other hand, the recipient who still owns a home at the time of death need not apply those assets toward the cost of care, unless the state has established an estate recovery program.

About 14 Percent of Medicaid Nursing Home Recipients Own a Home

In the eight states reviewed, the percentage of nursing home recipients in our sample who owned a home or other real property when they applied for Medicaid ranged from 8.5 percent in Pennsylvania to 21 percent in Wisconsin (see table 2.1). An average of 14 percent of Medicaid nursing home recipients sampled in the eight states owned real property. Of the property owners, only about 7 percent indicated they were still making mortgage payments (see p. 48 for a more detailed discussion). In each state, our random sample consisted of 200 individuals 65 years or older, whose Medicaid applications we reviewed to identify whether they owned a home or other real property at the time of application.

The average value of real property owned by Medicaid nursing home recipients sampled in the eight states was $30,712, ranging from about $23,000 in Michigan to $39,000 in Washington (see table 2.1). We determined the value of the properties from county records (see p. 49 for a discussion of these sources).

Table 2.1: Projected Number and Value of Real Properties Owned by Medicaid Recipients in Eight States (1985)

State	Recipients admitted to nursing homes	Projected home ownership		Average value of real property[a]	Projected total value of property
		Number	Percent		
California	29,416	3,677	12.5	$36,168	$132,989,736
Michigan	9,711	874	9.0	23,287	20,352,838
Ohio	13,000	2,340	18.0	28,214	66,020,760
Oregon	3,018	453	15.0	37,234	16,867,002
Pennsylvania	17,374	1,477	8.5	26,035	38,453,695
Texas	14,980	2,846	19.0	25,476	72,504,696
Washington	7,122	783	11.0	39,162	30,663,846
Wisconsin	9,520	1,999	21.0	32,012	63,991,988
Total	**104,141**	**14,449**	**(14.0)**	**$30,712**	**$441,844,561[b]**

[a]Represents the average value of real property for the 228 recipients in the eight state samples.

[b]This figure is accurate within plus or minus $84,862,650 at the 95-percent confidence level

We estimate that 14,449 Medicaid recipients admitted to nursing homes in 1985 in the eight states at the time of admission owned real property valued at about $442 million.

Medicaid Pays Millions in Nursing Home Bills for Homeowners

For each of our sample recipients who owned a home or other real property, we estimate that Medicaid will pay nursing home costs ranging from $10,281 in Texas to $14,745 in Washington over the duration of his or her nursing home stay (see table 2.2). For the eight states we reviewed, we project total Medicaid payments of about $176 million for the estimated 14,449 recipients admitted to nursing homes in 1985 who owned real property. We based our estimates on actual Medicaid payments in 1985 and 1986, and projected payments for those who were still in the homes at the beginning of 1987.

Table 2.2: Estimated Medicaid Payments for Nursing Home Residents in Eight States Who Owned Real Property (1985)

State	Projected recipients owning real property	Average Medicaid payments	Estimated total Medicaid payments
California	3,677	$12,523	$46,047,071
Michigan	874	13,409	11,719,466
Ohio	2,340	12,649	29,598,660
Oregon	453	9,674	4,382,322
Pennsylvania	1,477	10,463	15,453,851
Texas	2,846	10,281	29,259,726
Washington	783	14,745	11,545,335
Wisconsin	1,999	13,802	27,590,198
Total	**14,449**	**$12,193**	**$175,596,629**[a]

[a]This figure is accurate within plus or minus $33,912,950 at the 95-percent confidence level.

Medicaid Recovers Little of Its Nursing Home Costs From Recipients' Estates

A state cannot use a Medicaid recipient's home equity to defray Medicaid costs unless the home is either (1) sold before the recipient dies or (2) the state operates an estate recovery program (see pp. 10-12). At the time we completed our field work, 95 of the 228 recipients in our samples who owned a home at the time they entered the nursing home were deceased. Of those 95 recipients, 91 owned their homes at the time of death. Because Medicaid recipients in the eight states generally retained ownership of their homes until death, only Oregon and California—the two states with recovery programs—could use recipients' home equity to defray Medicaid costs.

In the eight states reviewed, only about $19.5 million of the estimated $176 million in Medicaid payments for recipients admitted to nursing homes in 1985 who owned real property will be recovered (see table 2.3). To determine the potential effect of a recovery program on Medicaid costs, we applied the recovery procedures used by Oregon to the cases in all eight states. Oregon recovers up to the actual cost of Medicaid services provided from the recipient's estate, or, if there is a surviving spouse, from the spouse's estate. (See app. I for a more detailed discussion of the methods used to estimate potential recovery.)

Table 2.3: Projected Recoveries From Estates of Medicaid Recipients Admitted to Nursing Homes in Eight States (1985)

State	Estimated recoveries under 1986 state law	Projected recoveries based on Oregon law	Increase
California	$15,801,100	$26,740,760	$10,939,660
Michigan	0	9,869,386	9,869,386
Ohio	0	21,226,600	21,226,600
Oregon	3,779,427	3,779,427	0
Pennsylvania	0	8,447,847	8,447,847
Texas	0	20,297,900	20,297,900
Washington	0	6,890,606	6,890,606
Wisconsin	0	18,368,170	18,368,170
Total	**$19,580,527**	**$115,620,696[a]**	**$96,040,169**

[a]This figure is accurate within plus or minus $23,835,640 at the 95-percent confidence level.

By establishing recovery programs patterned after Oregon's, the six states without recovery programs could defray about $85 million of the estimated $125 million in Medicaid nursing home payments they will incur for recipients owning a home. Although California operates a recovery program, it does not attempt to recover from the estates of surviving spouses because state law does not authorize such recoveries. We estimate that California could increase recoveries by about $11 million by recovering from the estates of surviving spouses. Overall, in the eight states we sampled, about one-third of the recipients who owned property had a surviving spouse, making recoveries from their estates an important component of states' efforts to defray Medicaid costs.

During the course of our review, Texas and Washington enacted legislation establishing recovery programs. However, neither program offers the recovery potential of the Oregon program. Specifically:

- Texas's law does not authorize recovery from spouses' estates. About $6 million of the approximately $20 million in projected recoveries in Texas would be from spouses' estates.
- Washington's law, enacted in 1987, does not allow recovery from real property sold for less than $50,000 if there are any surviving children, even if they have reached adulthood. For real property sold for over $50,000, recovery is limited to 35 percent of the value if there is an adult child. These provisions reduce projected recoveries in Washington from about $7 million to about $218,000.

Expanding Programs to Recover From Estates of Institutionalized Recipients Under Age 65 Would Increase Recoveries

Neither Oregon nor California attempts to recover from the estates of institutionalized recipients under age 65. Officials from both states told us that they believed that recoveries from recipients under age 65 were authorized by section 1917 only if a lien were placed before the death of the recipient. But our analysis of the law and discussions with HCFA officials indicate that recoveries from the estates of permanently institutionalized recipients under 65 are permitted. Because the rate of home ownership is higher for individuals under age 65 and about 14 percent of skilled nursing home residents were under 65 in fiscal year 1983,[1] recoveries could be significant.

Section 1917(b) reads, in pertinent part,

"(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except—

"(A) in the case of an individual described in subsection (a)(1)(B) of this section [which refers to permanently institutionalized individuals whom states require to pay most of their income for medical care], from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

"(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate."

California's Department of Health Services interprets section (b)(1)(A) as applying only to institutionalized recipients whose estate or property is subject to a lien, Department officials told us. Their recovery program, they said, is operated under section (b)(1)(B), which limits recovery to estates of recipients 65 years of age or older.

Officials from Oregon's Estate Administration Unit also believed section 1917 precluded recoveries for recipients under age 65, but for a different reason. They interpreted the section as requiring that both "A" and "B" must be satisfied in order to recover. In other words, they believed the individual had to be both institutionalized and over 65 years of age before estate recovery could be done.

HHS may have contributed to the confusion by its statement in the Federal Register notice that published the final regulations to implement the lien and estate recovery provisions of TEFRA:

[1] HCFA, Program Statistics, Medicare and Medicaid Data Books, 1986, p. 86.

"These regulations . . . provide that States may recover funds for correctly paid Medicaid claims from the estate of an individual who was 65 years of age or older when he received Medicaid. In addition, States may adjust or recover Medicaid funds by foreclosing on a lien imposed on the real property of an institutionalized individual when an individual of any age dies, sells or transfers his or her property."

This implies that recoveries from the estates of individuals under 65 can only be accomplished by "foreclosing on a lien."

The criteria are somewhat confusing, an official from HCFA's Bureau of Eligibility, Reimbursement, and Coverage acknowledged. He has received a number of calls about whether estate recoveries are permitted for permanently institutionalized Medicaid recipients under age 65. HCFA interprets the law to permit recovery from these persons, he said, even though liens have not been attached to the property.

A state may recover correctly paid benefits in two categories of cases according to section 1917(b). The cases are those of (1) an individual who is permanently institutionalized and (2) "any other individual who was 65 years of age or older." Our interpretation of "any other individual" is that it establishes a separate, distinct category that refers to individuals other than those who are permanently institutionalized, and only for this group is age a consideration in pursuing estate recoveries. For permanently institutionalized recipients, we believe recovery may be made pursuant to a lien imposed on account of medical assistance paid, as well as from their estate.

Some Medicaid recipients who are under 65 may have extensive estates, especially those who were injured and received settlements to cover their disabilities, according to the manager of Oregon's Estate Administration Unit.

Oregon Recovery Program an Example for Other States

Although 21 states and the District of Columbia have active estate recovery programs to recover correctly paid benefits, none has recovered more per recipient than the Oregon program. Additional states are in the process of implementing estate recovery programs. Still others, according to the HHS Inspector General's June 1988 report, are considering establishing or expanding such programs.

Despite the increasing interest in estate recovery programs, HCFA has little information on them and, until recently, has provided limited technical assistance to states interested in establishing or improving a recovery program. As a result, states have asked Oregon for technical assistance. To get a better idea of why Oregon has been more successful than other states in obtaining estate recoveries, we discussed with Oregon officials and advocacy groups for the elderly the elements of the Oregon program that they think are key to its success. The key elements cited were (1) establishing enabling legislation, (2) maintaining flexibility in dealing with hardship cases, (3) securing recoveries from estates of surviving spouses, (4) establishing a central recovery unit, (5) appointing a conservator to handle incompetent recipients' assets, and (6) establishing an effective transfer-of-assets policy.

HCFA Provides Limited Technical Assistance

HCFA headquarters and regional office officials have not obtained or analyzed data on estate recovery programs and, therefore, provide limited technical assistance to states in establishing or improving recovery programs. HCFA's Central Office does not obtain information on the programs or take a proactive role in encouraging states to establish or improve programs, according to an official from HCFA's Bureau of Eligibility, Reimbursements, and Coverage.

Similarly, officials from the five HCFA regional offices we visited said that they knew which states had established recovery programs, but lacked detailed knowledge of the scope and structure of the programs. Although HCFA's Seattle regional office conducted a study in 1985 of the potential for estate recoveries in Idaho, the region had made no further efforts as of December 1988 to encourage the establishment of recovery programs.

As the implementation of the section 1917 provisions are optional, HCFA headquarters and regional office officials told us during the course of our review that they do not believe it is HCFA's responsibility to help, encourage, or provide information to states regarding recovery programs. States should be on their own to set up programs and should

obtain information on successful programs from each other, the officials said.

In commenting on a draft of this report, however, HHS said that it plans to take advantage of every appropriate opportunity to encourage states not pursuing estate recoveries, or pursuing them ineffectively, to institute effective recovery programs. HCFA's May 1988 State Agency Successful Practices Guide contains a chapter on estate recoveries profiling five states that have successful programs, HHS noted. The guide was distributed to all state agency heads, Medicaid directors, third-party liability managers, the National Conference of State Legislatures, the National Governors' Association, and all HCFA regional offices, according to HHS. In addition, HCFA has encouraged estate recoveries and the use of the guide in several national meetings during 1988, HHS stated.

Other actions taken during 1988 to improve estate recoveries include distribution of the HHS Inspector General's comprehensive study on states' estate recovery programs to all state Medicaid agencies and establishment of a departmental task force to evaluate the administrative and regulatory changes needed to improve states' estate recovery programs, HHS noted.

These recent actions are a step in the right direction and should help expand estate recovery programs. The successful practices guide, however, is, in our opinion, of limited usefulness to states wishing to establish or improve estate recovery programs. Specifically, the guide discusses few of the key elements that help account for the success of the Oregon program, and points out ways that the five "profiled" states could improve their programs, such as by recovering from the estates of (1) surviving spouses and (2) recipients who were under age 65 when admitted to the nursing home. The Inspector General's report, in our opinion, provides more useful guidance to states wanting to establish or improve recovery programs.

The Recovery Process in Oregon

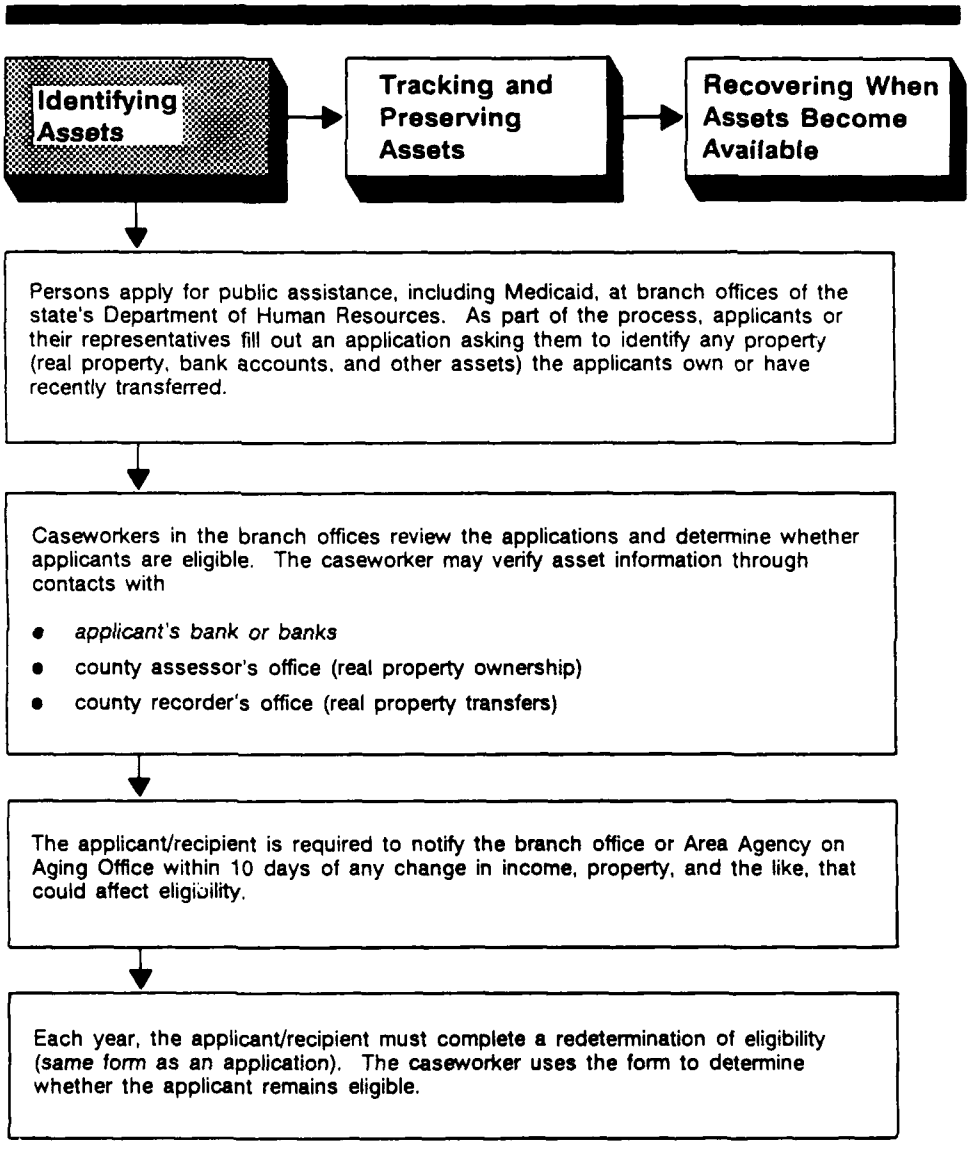
Oregon enacted legislation in 1949 authorizing the state to recover the cost of state-provided cash assistance to the elderly. In 1975, legislation was enacted authorizing recovery of the cost of medical assistance provided to persons 65 and older. In 1986, Oregon recovered $3.7 million, and spent about $376,000 to operate the recovery program—a benefit-to-cost ratio of 10 to 1.

The recovery process can be broken into three parts: (1) identifying an applicant's assets, (2) tracking and preserving assets while assistance is provided, and (3) recovering from the recipient's estate.

Identifying Applicants' Assets

A recovery program depends on good information to identify assets held or transferred by public assistance recipients. Oregon's information gathering process routinely begins with the caseworker at the time individuals apply for food stamps or financial, medical, or social services assistance (see fig. 3.1). During the application process, applicants or their representatives are asked for information on real property, bank accounts, or other assets currently held or disposed of within 2 years of applying for assistance.

Figure 3.1: Oregon's Recovery Process: Identifying Assets

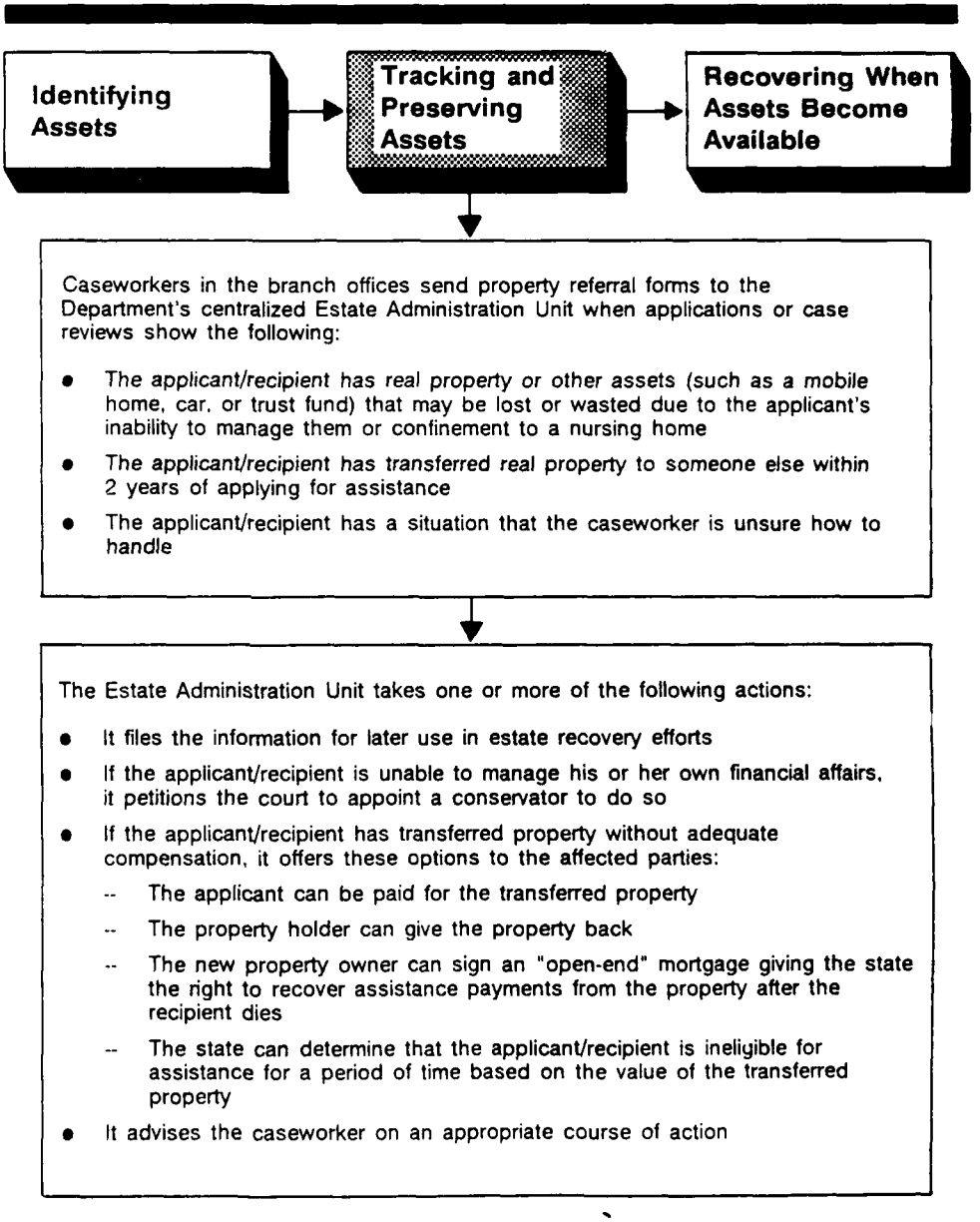


The caseworkers screen each application to make sure that the necessary information is provided and to determine whether the applicant qualifies for assistance. The caseworkers may also follow up and verify the information provided. For example, the caseworker might contact the county assessor's office to verify information the applicant provided on real property ownership. The data are then sent to Oregon's Central Recovery Unit, which uses the information for estate recovery purposes.

Tracking and Preserving Assets

Once identified, assets should be tracked to ensure that they are being used to pay for the recipients' care and not being given away to others. In Oregon, caseworkers complete a property referral form and forward it to the central state recovery unit when they identify applicants/recipients who own or have recently transferred assets (see fig. 3.2). The form contains information on real property, mobile homes, cars, boats, and other assets, such as trust funds that the individual owns or has transferred. Involving the recovery unit early helps the unit to better track applicants'/recipients' assets. If an individual is unable to manage his or her own affairs, the state petitions the court to appoint a conservator to assist the recipient.

Figure 3.2: Oregon's Recovery Process: Tracking and Preserving Assets



The caseworkers and estate administrators also want to prevent applicants/recipients from giving away their assets without adequate compensation. When they find that applicants or recipients have given away assets at less than fair market value within 2 years of applying for Medicaid or at any time after applying, Oregon gives the parties involved three options to avoid a period of ineligibility:

- The applicant/recipient can be paid an adequate amount for the assets. This would make the money received available to pay for care before the individual could become Medicaid-eligible.
- The property holder can void the transfer and give the assets back. This step makes the assets available to pay for care before Medicaid eligibility is established or, in the case of exempt property, available for possible recovery of costs at a later date.
- In the case of real property, the property holder can sign an "open-end mortgage" with the state. This mortgage allows the property holder to keep the property. But under its terms, after the Medicaid recipient dies, the property holder pays the state (up to the value of the property) for the cost of care provided.

If the applicant/recipient and property holder do not agree to one of the above actions, the applicant/recipient is declared ineligible to receive Medicaid assistance for a period of time. At the time we completed our review, if the fair market value of the asset minus the amount of compensation received by the applicant/recipient is less than or equal to $24,000, the period of ineligibility is 24 months. Should the uncompensated value exceed $24,000, the number of months the individual is ineligible for assistance equals the uncompensated value divided by $1,000. For example, if property worth $30,000 was sold for $2,000, then the uncompensated value was $28,000. The period of ineligibility would be 28 months, or $28,000 divided by $1,000.

Recovering for Care Provided

A process to recover from recipients' assets the cost of care provided is the final step in an effective recovery program. In Oregon, recoveries can take place while the individual is receiving assistance or after the individual dies. In addition, Oregon law allows recovery from the spouse's estate if the state did not recover from the recipient's estate.

Recovering From Living Recipients

The state may recover from living recipients for care provided. This generally occurs when a recipient owns a home but is living in a nursing home and is not expected to return home, the recovery unit manager said. If the home is sold, the proceeds are used to reimburse the state for past care provided. Any remaining assets are held in trust and used to pay for the recipient's present and future care. When the recipient dies, any money not used to defray Medicaid costs remains part of the estate to go to the recipient's heirs, according to the manager.

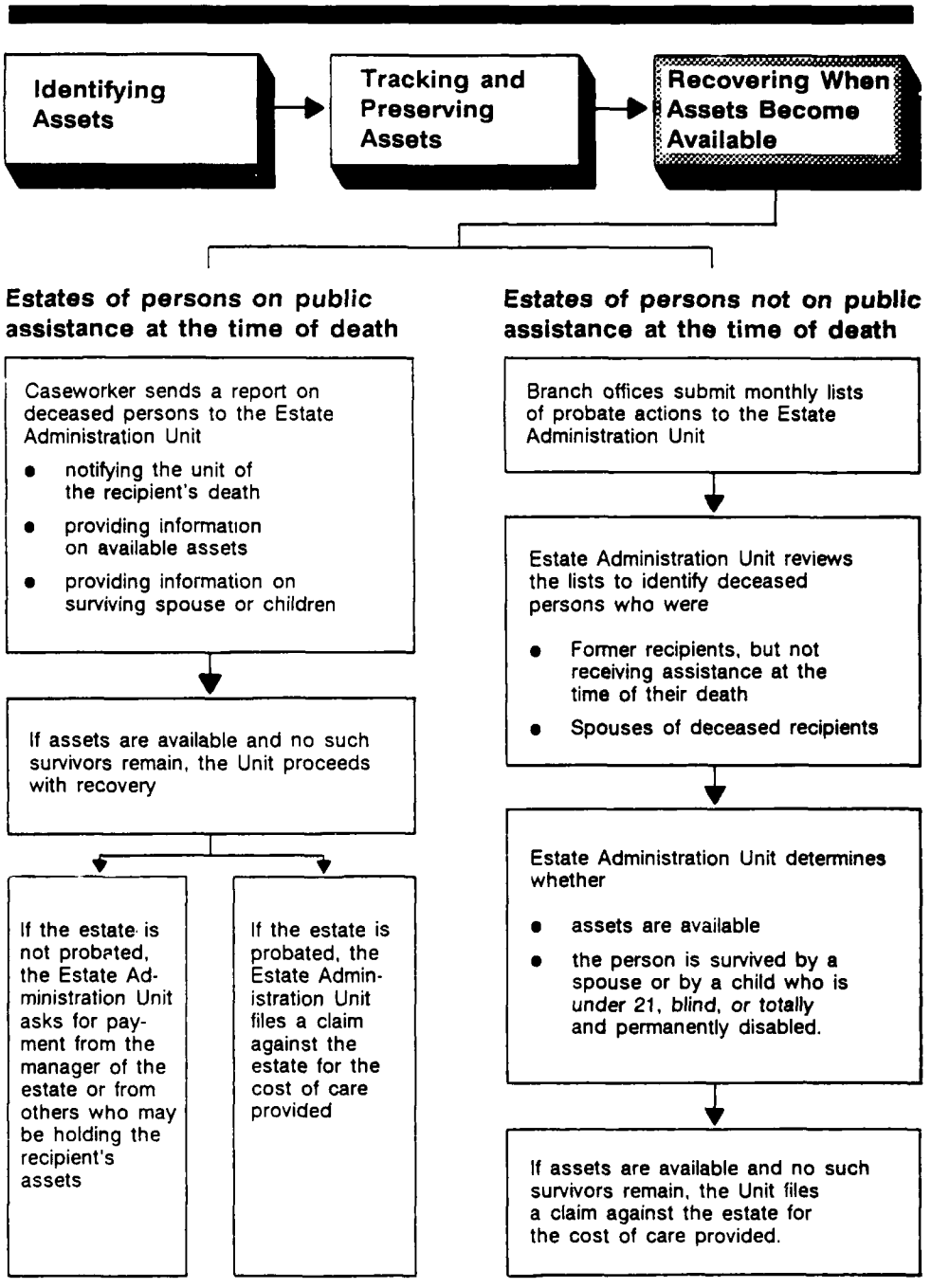
The recipient may sell the home, but hold the mortgage on the home, receiving monthly mortgage payments from the buyer. An estate administrator explained that these payments are considered income and are used to offset the current cost of care. However, the state may recover for the cost of care provided before the home was sold from any assets remaining in the estate at the time of the recipient's death.

Recipients also may assign the title of their real property to the state in consideration for all past, present, and future care. The state then can sell the property, and the proceeds are considered to be part of the state's recoveries, according to an estate administrator.

Recovering From Deceased Recipients

When an individual dies while receiving Medicaid assistance, the recovery unit takes steps to recover for the cost of care provided (see fig. 3.3). Prompt notification of a recipient's death is important, according to the recovery unit manager; the caseworker must complete a report on the deceased recipient and forward it to the recovery unit within 5 days. The report contains information on the recipient's assets and surviving family members. If the recipient had assets at the time of death and had no surviving spouse or children who are under 21, blind, or totally and permanently disabled, the unit takes steps to recover the costs of care provided.

Figure 3.3: Oregon's Recovery Process: Recovering When Assets Become Available



The recovery procedure the unit follows depends on the amount and type of assets the recipient owned. If it appears that the estate will not

be probated because of the small value of the assets, the unit requests reimbursement from the individual responsible for managing the recipient's estate. Letters are also sent to the recipient's banks and the nursing home, requesting that the recipient's funds be forwarded to the state. If a claim with a higher priority than medical expenses (funeral expenses, for example) is filed against the estate, the state reimburses the appropriate amount to the claimant from the money it receives.

If a recipient had assets of substantial value, the recovery unit asks the recipient's family to either repay the state for the public assistance provided (up to the value of the recipient's assets) or probate the estate. If the estate is probated, an estate administrator files a claim against the estate in the county probate court for the value of the public assistance provided. The state's claim for public assistance would be paid from the estate after the costs of administering the estate, the expenses of a funeral (up to $1,000), and federal taxes are paid. The claims of heirs are paid only after state claims are satisfied. According to Oregon's Estate Administration Unit, if there are sufficient assets in the estate but no person with a higher preference is willing to become the personal representative of the estate, the unit will petition the court to nominate a personal representative.

Recovering From Former Recipients or Spouses

Oregon also has a system to identify and recover from individuals who received Medicaid or other assistance in the past, even if they were not receiving assistance at the time of death. To identify these former recipients, the unit reviews monthly lists of probate court actions sent by each branch office. If a former recipient is found and has no surviving spouse or a child who is under 21, blind, or disabled, the unit calculates the amount of public assistance and files a claim against the individual's estate in the probate court.

The state is also authorized to recover from the estate of a deceased recipient's spouse if both the recipient and the spouse are deceased and there are no surviving children under 21, blind, or disabled. For example, when a recipient dies but is survived by a spouse, the unit takes no action to recover any funds at that time. Instead, the unit fills out a data card on the spouse as a basis for later recovering from the spouse's estate when he or she dies. Each month, the county probate lists are reviewed and compared with the list of spouses to see if any have died. If there is a match, the state files a claim against the estate for public assistance provided to the husband, wife, or both.

Key Elements of Oregon's Recovery Program

There are several features of the Oregon program that help account for its success and acceptance by Medicaid recipients. These elements are discussed below.

Element 1: Oregon Enacted Laws Authorizing Estate Recoveries

Oregon enacted laws specifically authorizing the recovery program and establishing the conditions under which recoveries will be authorized.

Two of the states included in our review, Pennsylvania and Michigan, said that their attempts to operate estate recovery programs administratively were blocked by legal challenges. In Pennsylvania, a state attorney told us that a class action suit brought against the state caused the state to disband its recovery program because recovery was not permitted under existing state law, and that, under section 1917, recovery was optional, not required. Similarly, Michigan discontinued its estate recovery program because of a binding opinion issued by the state's Attorney General concluding that the state could not recover because state laws did not specifically authorize it.

As discussed on page 26, Oregon law has authorized estate recoveries since 1949; specific legislation authorizing recoveries from the estates of Medicaid recipients 65 years of age or older was enacted in 1975. Other Oregon laws authorize recovery of cash assistance provided by Oregon's Adult and Family Services Division and certain assistance provided to the blind or disabled. Other laws give the state a priority claim against the estate, authorize the appointment of a conservator to ensure the continued availability of assets, and authorize recoveries from the estates of surviving spouses.

Element 2: Oregon Maintains Flexibility in Dealing With Hardship Cases

Oregon has allowed sufficient flexibility to ensure that estate recoveries do not create undue hardships on the recipient's heirs, according to advocacy groups for the elderly in the state.

In designing their Medicaid programs, states should strike a balance between the needs of Medicaid recipients and their heirs and the needs of the government to contain Medicaid spending. Officials from Michigan and Pennsylvania told us that they had not considered establishing recovery programs by law because of expected political pressure from special interest groups concerned about the effect recovery legislation would have on the desire of the elderly to leave an estate. For example,

a Pennsylvania official told us that legal services and welfare rights advocacy groups were active in the state and that the legislature was not likely to approve such a program. Similarly, an Ohio official told us that the Ohio legislature did not fund a recovery program.

Although Washington enacted recovery legislation in 1987, the scope of the program was narrowed because of political sensitivity during deliberations. An early proposal would have permitted recovery from the estates of any deceased Medicaid recipient without a surviving spouse or dependent child. However, after hearings on the bill, it was amended to exempt recoveries for property valued below $50,000 if there are any children, regardless of age.

We contacted several organizations in Oregon that provide services to senior citizens or act as advocates for seniors, including the Gray Panthers, United Seniors, and the Legal Aid Service-Senior Law Project. A volunteer for the Gray Panthers, who serves as the vice chairperson for United Seniors, a coalition of senior service groups, said he had never heard anyone complain about the estate recovery effort. According to the staff attorney for the Senior Law Project in Portland, the state has been flexible in cases where recovery would cause a hardship for recipients' adult children or siblings.

We also discussed estate recovery with national representatives of AARP and the Gray Panthers. AARP has not established a formal policy position on estate recoveries, a legislative representative said, but is not opposed to the concept. She said that the program should be administered in a way that it does not intimidate people, minimizes confusion, and protects the interests of caretakers of the elderly. The concept of liens frightens people, she added.

The Gray Panthers do not have a national policy on estate recoveries under Medicaid, an official said, but she had serious questions about having long-term care coverage provided under Medicaid. As long as long-term care is provided under Medicaid, however, it should be uniform in all states, she said. It is not fair, in her view, that some adult children inherit from their parents and others do not.

As discussed above, advocacy groups for the elderly within Oregon think that the Oregon program allows sufficient flexibility to protect the interests of caretakers and the program has accomplished recoveries without the use of liens.

Element 3: Oregon Authorized Recoveries From the Estates of Surviving Spouses

Oregon increased its recoveries by enacting a law to authorize recoveries from the estates of surviving spouses.

Because about one-third of Medicaid nursing home residents we sampled who owned a home had a spouse, and recoveries are allowed only when there is no surviving spouse, a significant portion of potential recoveries is lost unless a state authorizes recoveries from the estates of surviving spouses.

A state can recover from the estate of the surviving spouse only if it has enacted a law authorizing such recovery. Nothing in the federal Medicaid statute explicitly authorizes or forbids recovery from the estate of the surviving spouse. Section 1917(b) prohibits recovery of correctly paid Medicaid benefits except from the estate of the Medicaid recipient and provides that recovery "may be made only after the death of the individual's surviving spouse." Although the statute does not provide a clear basis for a state to proceed against the surviving spouse's estate, one state court—the only court we found that has addressed an issue relevant to this question—construed section 1917(b) as not prohibiting recovery from the estate of a surviving spouse.[1]

Oregon law allows the state to recover from the estate of the spouse after both the recipient and the spouse are deceased and there are no children under age 21, blind, or disabled. Of the $3.8 million in potential recoveries we identified for recipients admitted to Oregon nursing homes in 1985, we estimate that about $600,000 will come from the estates of married recipients. In the other seven states, we identified about $46.4 million in potential recoveries from the estates of married recipients.

Element 4: Oregon Established a Central Recovery Unit

To facilitate recoveries and reduce administrative costs, Oregon established a central unit to administer estate recoveries for all programs.

One concern expressed in nonrecovery states was the cost effectiveness of recovery programs. For example, an Ohio official believed that the administrative costs of recovery would outweigh any recoveries. One

[1] Matter of Estate of Imburgia, 487 N.Y.S. 2d 263 (Sur. Ct. 1984). In this case, the State of New York had a statute authorizing recovery from the estate of a responsible relative (such as the surviving spouse). The court, faced with the question of whether the New York statute was invalid because it conflicted with section 1917(b), found no conflict. The executors of the estate had argued that since section 1917(b) provided no recovery except against the estate of the recipient, it implicitly prohibited recovery against the estate of a responsible relative.

Wisconsin official was hesitant to establish an estate recovery program, she said, because such programs do not always receive prompt notice of a Medicaid recipient's death and would have difficulty submitting claims in time for probate.

Oregon established a central recovery unit, known as the Estate Administration Unit. The unit recovers for services provided through the Mental Health Division, the Adult and Family Services Division, and the Senior Services Division. Approximately 95 percent of the recoveries are for services provided to those 65 years of age or older through the Senior Services Division, according to the program manager. By establishing a central unit, the state avoids the expense of operating separate units for each recovery program.

The Estate Administration Unit has a staff experienced in legal, property, and probate transactions. A manager heads the unit and is assisted in carrying out the estate recovery process by three estate administrators. All four positions require a law degree or an equivalent background in law and experience in real property transfers, probate laws, and interpreting wills and assets. A clerical staff of five and a resource coordinator assist the administrators.

Element 5: Oregon Appoints Conservators for Incompetent Recipients

To protect both the interests of the recipient and the state, Oregon petitions the court to appoint conservators to manage the financial affairs of recipients who are mentally or physically unable to manage their own affairs.

Oregon law allows the state to petition the court for the appointment of a conservator to assist a recipient if the individual is unable to handle his or her affairs due to physical or mental illness. The individual's caseworker, with the assistance of the physician, nurse, or nursing home administrator, determines whether a recipient is competent to manage his or her own affairs. The property referral form provides the recovery unit with the information, such as the amount and type of assets, needed to file the court petition.

Element 6: Oregon Maintains an Effective Transfer-of-Assets Policy

To help ensure that a recipient's assets are not sold or given away before the state can recover, Oregon established an effective transfer-of-assets policy.

Oregon has enacted laws that empower the state to void transfers of real or personal property when the recipient did not receive adequate payment. As discussed on pages 30 and 31, Oregon provides recipients several options when an illegal transfer has occurred. These options help ensure that the recipient's available resources remain available to pay for his or her care.

Conclusions, Matters for Consideration by the Congress, and Agency and State Comments

Conclusions

Estate recovery programs increase equity by requiring all Medicaid nursing home recipients to apply their assets equally toward the cost of their care. In those states without an estate recovery program, only those recipients who own a home at the time of death are allowed to leave an estate. Recipients with savings, but not a home, are forced to apply those savings toward the cost of care. Several benefits offered by estate recovery programs are that they

- help to keep the Medicaid program focused on its intent. In all 50 states, a Medicaid recipient who sells assets while alive must use the proceeds to pay for care. Forty-nine states have laws prohibiting recipients from avoiding this requirement by transferring assets without compensation. Without a recovery program, however, a state has no mechanism for receiving compensation after a recipient has died leaving no spouse or blind, disabled, or dependent child.
- can be structured so as to recover costs without placing undue hardships on the elderly. A recovery program like Oregon's demonstrates that the interests of the state and the elderly and their heirs can be served. Institutionalized recipients need not give up their homes to receive benefits when they or their spouses are alive. In most cases, recovery is initiated only after the death of the recipient and the recipient's spouse.
- can more than pay for themselves. In 1986 Oregon's program recovered $10 for every $1 spent on the program. From a financial standpoint, the cost and effort involved in setting up a recovery program appear to be justified.
- help to meet future financial strains on the government's health care efforts. In the near future, the number of older Americans will grow rapidly, and this growth likely will bring an increased demand for nursing home care. Recovery programs can help ease the strain on already limited government resources.

HHS should do more to promote the establishment and improve the effectiveness of estate recovery programs. Specifically, the Department, in preparing the required report to the Congress on the means for recovering the cost of Medicaid services from the estates of institutionalized recipients, should develop a legislative proposal that would require states to establish estate recovery programs. In addition, the report should include information on effective estate recovery practices, including recoveries from spouses' estates and estates of recipients under age 65 if they received Medicaid assistance.

Matters for Consideration by the Congress

The Medicare Catastrophic Coverage Act of 1988 makes mandatory the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 pertaining to restrictions on transfers of assets for less than fair market value and extends the restriction period on transfers from 24 to 30 months. GAO believes the Congress should consider making mandatory the establishment of programs to recover the cost of Medicaid assistance provided to nursing home residents of all ages, from either their estates or the estates of their surviving spouses. The establishment of such programs would help to ensure that assets preserved through the new transfer-of-assets provisions can be used to defray Medicaid costs.

HHS Comments and Our Evaluation

HHS said that it generally agreed that estate recovery programs have potential to offset Medicaid costs (see app. II). But it said our legislative proposal should be more specific, better justified, and address the appropriate balance between state flexibility and detailed federal requirements.

While states should retain flexibility in designing their recovery programs, we believe certain minimum requirements should be established at the federal level. As HHS correctly notes in its comments, states have not taken full advantage of the authority to establish estate recovery programs that has existed for over 20 years. And, when recovery programs have been established, they have sometimes contained such severe restrictions that only limited recoveries are possible. For example, as discussed on pages 22 and 36, Washington's estate recovery program is structured to recover only a small fraction of the assets available, the remainder going to the surviving children, even if they have reached adulthood. Accordingly, we believe that estate recovery programs should include provisions for (1) recovering Medicaid costs from estates of recipients of all ages, not just those over 65, (2) recovering from the estates of surviving spouses, and (3) establishing the Medicaid program as a creditor whose claims against the estate have priority over those of heirs other than the surviving spouse or dependent child. States should, in our opinion, retain the flexibility to design the recovery process with HCFA oversight to help ensure that those processes are effective in identifying, tracking, and recovering assets from recipients' estates or the estates of their surviving spouses.

Mandating estate recoveries would, HHS said, amend national policy on such fundamental issues as the disposal of homes of the elderly, the intergenerational transfer of wealth, and the traditional authority of states to set probate policy. Because of these fundamental public policy

issues, HHS said that it favors a two-pronged approach. First, HHS would encourage broad public discussion in the Congress and other appropriate forums on the complex underlying issues affecting estate recovery programs. Second, HHS would pursue limited legislative, regulatory, and program management change to enhance program effectiveness. The program management aspects are, according to HHS, being addressed by HCFA, and the legislative and regulatory aspects will be addressed in the departmental study.

We agree that the issues surrounding estate recovery programs are politically sensitive and that the Congress is an appropriate public forum to debate those issues. We also believe, however, that HHS, as the federal agency responsible for administering the Medicaid program, should assume a leadership role in that debate.

Further, the fundamental issues to which HHS alludes were to a large degree decided by the Congress through TEFRA. As HHS noted in its implementing regulations, the TEFRA provisions are ". . . intended to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children, will be used to defray the costs of supporting the individual in the institution." Therefore the future debate should focus more on the best way to (1) ensure that those resources are used to defray Medicaid costs and (2) eliminate the inequity that exists in those states that do not have effective recovery programs. Current law generally allows the intergenerational transfer of wealth by Medicaid nursing home residents only in those states that do not have an effective estate recovery program and then only if the recipient still owns the home at the time of death. Mandating estate recoveries would, in our opinion, address both issues.

With respect to HHS's comment that mandating estate recoveries would alter the traditional authority of the states to set probate policy, we are proposing no fundamental change in this authority. The action we suggest would give the Medicaid program the right to settle claims against the estates like other creditors.

HHS said that we did not specially address the difficult issue of how to recover Medicaid costs from surviving spouses' estates, and said that there will be instances where the spouse outlives the Medicaid recipient by many years, moves to a different house or different state, or remarries. As discussed on page 49, we recognized that Medicaid may not be

able to collect 100 percent of Medicaid costs in these cases, and in making our savings estimates, we used only 50 percent of the value of the real property available to offset Medicaid costs. An Oregon official said that Oregon has successfully collected from the estates of surviving spouses and some states, including California, see promise in expanding or changing their programs to increase potential recoveries.

Potential recoveries are overstated because of changes in the transfer-of-assets rules mandated by the Medicare Catastrophic Coverage Act, HHS maintains. Our estimates were based on home ownership at the time of Medicaid application for a sample of recipients admitted to nursing homes in 1985. Because the transfer-of-assets provisions of the Medicare Catastrophic Coverage Act apply only to resources disposed of on or after July 1, 1988, they would have little effect on the savings projections for our sample population. For those admitted to nursing homes in the future, however, we believe the act will increase, not decrease, potential recoveries. First, as discussed on pages 13 and 14, the spousal impoverishment provision of the act will make it easier for middle-income elderly to qualify for Medicaid by requiring states to exclude more income and resources in determining eligibility if there is a noninstitutionalized spouse. Because home ownership generally increases with income, the potential for estate recoveries should also increase. Second, by extending the restriction on transfers of assets to 30 months, the act should help ensure that more assets remain available for eventual recovery.

HHS also stated that our savings estimates are based on the assumption that each state could perform as effectively as Oregon. HHS does not believe that larger states could achieve the same percentage savings that Oregon realized. Our savings estimates were based on actual cases reviewed in each state, not on savings projections for Oregon. As shown on pages 19 to 22, the potential recovery in each state was based on the percentage of Medicaid recipients who owned homes, the average value of the homes, and the estimated Medicaid payments for those recipients. The potential percentage savings depends on those factors, not on the size of the state. California, for example, has demonstrated that a large state can operate an effective estate recovery program. Recoveries under California's program have increased from about $130,000 in 1981 to a projected $25 million in fiscal year 1989. As California recognizes in its comments on this report, its recoveries could be increased if it expanded its program to recover from the estates of recipients under age 65 and from the estates of surviving spouses.

State Officials' Comments and Our Evaluation

Comments were received from seven (California, Michigan, Ohio, Oregon, Pennsylvania, Washington, and Wisconsin) of the eight states included in our review. Generally, the states agreed with our findings and indicated that they would consider establishing or expanding estate recovery programs. Comments had not been received from Texas at the time this report was finalized.

California

The Deputy Director of Medical Care Services within California's Department of Health Services (see app. III) said that California prides itself as being a leader in estate recoveries and expects our report to help it in implementing some new processes. Specifically, the state is, according to the deputy director, preparing legislation to enable it to recover from the estates of (1) surviving spouses and (2) recipients who received nursing home services before age 65. California also hopes to further increase recoveries, which have grown from $130,128 in 1981 to a projected $25 million in fiscal year 1989, by providing further training at the county level to clarify the state's authority to file property liens against long-term-care beneficiaries (at any age) that declare no intent of returning home under current state laws.

Michigan

Based on the facts and recovery potential, Michigan will, according to the governor, (see app. IV) be exploring the possibility of implementing an estate recovery program. Michigan has not, the governor noted, had a statutory basis for a recovery program during the past 10 to 15 years. How well Oregon has done by enacting legislation specifically authorizing estate recoveries is interesting to note, the governor said.

With the clarification of federal intent in TEFRA and the Medicare Catastrophic Coverage Act of 1988, it would appear, the governor said, that many states will be addressing recovery potential. There is a potential for recovery of $7 to $9 million after a program is developed and operational, according to the governor.

Ohio

Ohio (see app. V) substantially agrees with our conclusions that estate recovery programs would increase equity, be cost effective, and help meet future financial strains on the government's health care efforts, according to the Director of Ohio's Department of Human Services. HCFA must take a more active leadership role in assisting the states with the development of estate recovery programs and should, according to the director, begin developing a legislative proposal that would provide a

more uniform program without the ambiguous language that currently exists as illustrated in section 1917(b) (see p. 23).

The director said that Ohio foresees having many more problems in implementing an estate recovery program than Oregon had. The Oregon program has, she noted, been operational for 25 years. She saw this as meaning that advocacy groups may have a different perspective on the programs in Oregon than the advocacy groups in Ohio. In addition, Ohio would face initial costs associated with development of an estate recovery program. Finally, Oregon has a state-administered program that allows it to administer the program from a centralized system, while Ohio has a county-administered system that places much of the burden on local county offices. These factors may, in the director's opinion, reduce the cost-benefit ratio.

We agree that the factors the director cites could reduce the cost-benefit ratio. For example, we recognize on page 36 that when Washington enacted recovery legislation in 1987, the scope of the program and potential recoveries were reduced during the deliberations because of the political sensitivity of the issue. We also discussed the views of national representatives of AARP and the Gray Panthers, groups that could help distill the political sensitivity of the issue if HCFA and the states work with them in developing their programs.

While start-up costs may, as the director suggests, reduce the initial cost-benefit ratio, the experience of California shows that an estate recovery program can soon pay for itself. As California noted in its comments, recoveries have grown from about $130,000 to an estimated $25 million during the first 8 years of the program. Finally, while having a county-administered Medicaid program may make it more difficult to administer certain aspects of an estate recovery program, it might facilitate other aspects, such as review of probate court actions and identification of real property transfers. Other states with locally administered Medicaid programs, such as New York, may be able to assist Ohio in structuring an effective recovery program. And, as the director notes, HCFA should take a more active role in assisting states with the development of estate recovery programs.

Oregon

The Governor of Oregon (see app. VI) said that Oregon looks forward to the challenge of maintaining its national leadership in the area of estate recoveries. Its goal, the governor said, is to increase estate recoveries while protecting the personal and property rights of the people it serves.

The program aggressively corrects disqualifying transfers of assets and is active in the preservation of assets so they may be available for the current cost of care as well as the estate. The governor expressed a willingness to continue to provide assistance to other states interested in implementing estate recovery programs.

Pennsylvania

The Deputy Secretary for Administration of Pennsylvania's Department of Public Welfare (see app. VII) said that although Pennsylvania did not agree with all the information in our report, it believes that establishing an estate recovery program is a viable option that will be given further consideration. Current state law does not, the deputy secretary said, allow for recovery of properly received benefits. Medicaid should not, he said, be forced to carry the burden of providing nursing home care while enlarging the estates of some recipients.

While the Deputy Secretary agreed that there could be increased revenues generated from operating an estate recovery program, he said that Pennsylvania did not necessarily agree with some of the assumptions used to calculate the probable dollar value of an estate recovery program in Pennsylvania. Specifically, he questioned our assumption that one-half of the market value of the home of married couples would subsequently be available from the estate of the spouse living outside the nursing home. The Deputy Secretary said that he suspects that this assumption is not practical in Pennsylvania and that the dollars recovered would probably be less than the $8.5 million we estimated.

As discussed on page 49, making accurate estimates of potential recoveries from spouses' estates was a problem because we had no way of knowing how much longer the spouse would live and what the estate would be worth at the time of death. Based on the success in recovering from spouses' estates reported by Oregon, we continue to believe our assumptions are reasonable, particularly considering the conservative approach followed in estimating the percentage of the property value to offset against Medicaid costs.

Washington

The Governor of Washington (see app. VIII) said that Washington is confident that its recently enacted estate recovery program will develop into a cost-effective program, although recoveries to date have been less than originally projected. The scope of the program was, the governor noted, limited to the filing of property liens or creditor claims after the death of medical assistance recipients who were older than 65 years of

age and to estates valued in excess of $50,000 unless there were no close surviving relatives. An amendment to reduce the $50,000 exemption to $35,000 is, according to the governor, being proposed for the 1989 legislative session.

As discussed on page 22, the limitations on the Washington recovery provisions will reduce projected recoveries from $7 million to $218,000. We believe Washington should consider making the Medicaid agency coequal with other creditors of the estate by eliminating the $50,000 exemption for estate recovery.

Wisconsin

The Secretary of Wisconsin's Department of Health and Social Services (see app. IX) said that Wisconsin has done considerable research in the area of estate recovery since we began our review and now believes that an estate recovery program operated with flexibility and a high degree of sensitivity to the needs of the elderly and their families can accomplish recovery goals without intimidation and confusion. Statutory language has, the secretary said, been proposed that would permit the state to recover Medicaid expenditures from an estate when there is no surviving spouse, minors, or disabled children.

Methodology Used to Determine Potential Recovery for Medicaid Recipients Who Own Real Property

This appendix explains the methodology we used to estimate potential estate recoveries in eight states (California, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin). We limited our review to determining the Medicaid costs that could be defrayed using recipients' real property because

- the home is the primary asset of most older individuals;
- the value of real property is public information obtainable from the county assessor's or treasurer's offices; and
- information on liquid assets, such as bank accounts, is difficult to obtain because of privacy concerns.

For the first 200 recipients from a random sample of 500 Medicaid nursing home recipients in each of the eight states, we obtained their Medicaid applications and/or subsequent redetermination of eligibility.[1] The universe for our samples consisted of all Medicaid nursing home recipients who were 65 years of age or older in 1985 and from whom the first Medicaid payment was for nursing home services provided in calendar year 1985. We determined whether the recipient was deceased and if so obtained the date of death. For recipients with real property we obtained the number of days of care or dates showing when nursing home care was provided and the actual Medicaid payments in 1985 and 1986.

We reviewed the data obtained for the 1,600 recipients (200 records in each of the eight states). If the application indicated that the recipient owned real property,[2] we contacted the appropriate county assessor's or treasurer's office to obtain the value of the property. If we were unable to determine clear property ownership or the value of the real property, we excluded the case from our calculation of potential recoveries.

Where the recipient had a life estate, we also excluded the case. Life estates occur when recipients have transferred their real property but

[1]For recipients whose Medicaid eligibility was established as a result of SSI eligibility, we obtained the SSI application from the Social Security Administration.

[2]Of the 228 property owners in our samples, 16 (7 percent) indicated on their Medicaid applications that they were making mortgage payments. Nine of the 16 were from our Oregon sample. An Oregon official said that the higher number of mortgages identified in the Oregon sample could be due either to the thoroughness of the Medicaid application process in Oregon or to the reporting of payments for state or federal loans for weatherproofing homes as mortgage payments. Because the projected value of the property in our samples was over twice the estimated Medicaid payments, we assumed that the homeowners had sufficient equity in the home to help defray Medicaid costs. Accordingly, we did not attempt to determine the amount of the outstanding mortgage for the 16 homeowners. Rather, we assumed that the entire value of the property was available to defray Medicaid costs.

retained the right to possess and use the property until death. While we counted these recipients as property owners, we excluded them from our recovery projections as they do not represent recovery potential.

To determine which property value to use for our estate recovery projections we developed the following priority order:

1. Actual sales price, as this should be the most accurate indication of the fair market value.

2. Fair market value from the city or county assessor's, treasurer's, or auditor's office.

3. Appraised value as determined by a real estate appraisal company.

4. Assessed value from the office of the city or county assessor's, treasurer's, or auditor's office. (In some locations this was the same as the fair market value.)

5. Value based on discussions with the caseworker.

6. Value stated in the Medicaid application.

We estimated the recovery potential based on the laws and procedures used for estate recovery in Oregon. When we had questions, we consulted with the manager of Oregon's Estate Administration Unit. The following assumptions were used in certain circumstances we encountered:

1. With respect to married recipients, Oregon allows recovery from the estate of a deceased recipient's spouse, and we wanted to include this potential amount in our projections. Yet making accurate estimates was a problem, as we had no way of knowing how much longer the spouse would live and what the estate would be worth at the time of death. We decided to assume that in cases where a Medicaid recipient was married, 50 percent of the value of the real property would be available to offset the cost of care. Our logic was that in some cases the full cost of the Medicaid care would be recovered and in other cases nothing would be recovered.

2. Where property was jointly owned by two unmarried individuals, we also assumed that 50 percent of the value of the property would be available to offset the cost of care.

3. Where property was owned by more than two individuals, we did not count the property as potentially recoverable. We decided that although a state might be able to recover the property, if it was jointly owned by more than two parties it should not be considered an available resource for the recipient.

4. Where the deed included a "right of survivorship" clause, we did not deem jointly owned property as a recoverable asset. In these cases, when one of the owners died, the property would pass directly to the other owner and would not be included as part of the decedent's estate, Oregon's Estate Administration Unit manager said. As this property would not be part of the decedent's estate, it would not be available for recovery.

After we determined the value of the recipient's share of the real property, we multiplied the value by 80 percent. We did this because a portion of the estate would be used to pay such estate expenses as real estate agent and attorney fees and, consequently, would not be available to defray Medicaid costs. Oregon's Estate Administration Unit manager agreed with this approach.

Before we could make projections we had to determine the amount of Medicaid claims paid for each recipient who owned real property. Whenever possible, we attempted to use actual payment amounts. From the states, we determined actual payments made in calendar years 1985 and 1986. We then compared the value of the real property available to defray Medicaid costs (i.e., 80 percent of the recipient's share of the property) and the Medicaid payments, as follows.

1. If the recipient was deceased, the potential recovery was the lesser of the value of the real property or the Medicaid claims paid.

Example: One recipient was a widower who owned real property valued at $27,385, of which $21,908 was available for recovery after allowing 20 percent for real estate and attorney fees. The recipient died in May 1986. All the Medicaid costs, totaling $10,937, could have been recovered from the recipient's estate.

2. If the recipient was alive but no longer in a nursing home, we compared the value of the real property and the Medicaid costs and took the lesser of the two.

3. If the recipient was alive and was in a nursing home for most of 1986, we assumed that the individual would be in a nursing home the rest of his or her life.

a. If the value of the real property was less than actual costs incurred, we assumed the recoverable amount was equal to the value of the property.

b. If the value of the property was greater than actual Medicaid costs paid in calendar years 1985 and 1986, we estimated the additional potential recovery, using a computer program that incorporated life expectancy tables. The additional potential recovery was calculated from five factors:

- recipient's age on January 1, 1987,
- recipient's sex,
- actual Medicaid costs paid for him/her in 1985 and 1986,
- average daily Medicaid cost for him/her in 1986, and
- value of the recipient's property available for recovery.

Example: One recipient in our sample was a widow who owned real property valued at $43,630. After deducting 20 percent to pay for any legal or real estate agent fees, the value of the property available to defray Medicaid costs was $34,904. The recipient was in the nursing home on Medicaid most of 1985 and all of 1986. Her Medicaid payments totaled $17,370. It appeared that she would spend the rest of her life in a nursing home. Because her Medicaid costs to date were less than the value of her property, we needed to estimate the additional costs that could be recovered. Using a computer program that factored in the recipient's age, sex, actual 1985 and 1986 Medicaid costs, daily cost in 1986, and value of property, we estimated that $14,574 more in Medicaid costs would be incurred that could later be recovered by the state. The total projected recovery was $31,944.

After we identified the individuals who owned real property and calculated the recovery potential for each, we estimated the potential recovery in each state. We also estimated the precision of the recovery estimates based on a 95-percent confidence level. In addition, we used stratified sampling procedures (each stratum consisted of the recoveries from one state) to estimate the recovery potential for the eight states combined with the precision of that estimate.

We did not take any steps to factor in inflation or to determine the present value of the amount recoverable.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington D.C. 20201

DEC 9 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Recoveries From Nursing Home Residents' Estates Could Offset Program Costs." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

As you know, the Office of Inspector General (OIG) has conducted a comprehensive study on States' estate recovery programs and has provided this information to all Medicaid State agencies. In addition, in response to an OIG report on this same subject earlier this year, the Department formed a task force which is evaluating administrative and regulatory changes to improve States' estate recovery programs.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosures

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Recoveries from Nursing Home Residents' Estates Could Offset Program Costs"

Overview

GAO studied the Medicaid nursing home programs in eight States, focusing particular attention on the estate recovery program operated by Oregon. GAO sought to discover the potential financial impact of such a program on Medicaid and whether it provides a mechanism for sharing the costs of nursing home care in a way that is acceptable to the elderly.

According to GAO, States can recover a substantial portion of Medicaid nursing home payments through establishment of effective estate recovery programs. GAO found that as much as two-thirds of the amount spent for nursing home care for Medicaid recipients who owned a home in the eight States studied could be recovered from their estates or the estates of their spouses. GAO believes that if implemented carefully, such programs can achieve savings without treating the elderly, inhumanely. In addition, advocacy groups for the elderly in Oregon (the State with the most effective estate recovery program) have not expressed concerns about the program.

Matters For Consideration By The Congress

The recently enacted Medicare Catastrophic Coverage Act of 1988 (MCCA) makes mandatory the transfer of assets provisions of the Tax Equity and Fiscal Responsibility Act of 1982 and extends the transfer period from 24 to 30 months. GAO believes the Congress should consider making mandatory the establishment of programs to recover the cost of Medicaid assistance provided to nursing home residents of all ages either form their estates or from the estates of their surviving spouses. The establishment of such programs would help to ensure that the assets preserved through the new transfer of assets provisions can be used to defray Medicaid costs.

Department Comment

We would generally agree that estate recovery programs have potential as a technique for assuring that a Medicaid recipient's assets, including a home, are used to offset program costs. However, we believe that GAO's recommendation to Congress needs to be more specific and better justified.

The recommendation is stated in extremely general terms. It does not take the next, more difficult step of examining what the basic elements of a legislative proposal might be. Two especially difficult issues that such a viable proposal would have to address and on which the GAO report is silent are:

-- the appropriate balance between State flexibility and detailed Federal requirements; and

-- cases involving recoveries from the estates of recipients' spouses.

As to the former issue, by pointing out the shortfall in voluntary State activity, GAO seems to imply that Federal requirements are necessary. By contrast, the very general tone of the recommendation seems to imply that GAO would leave the States in the lead in designing estate recovery programs, an outcome that would not be much different from the situation today.

As to the latter issue, it is conceivable that there will be instances where the spouse outlives the Medicaid recipient by many years, moves to a different house or different State, or remarries. Any of these events can radically affect the spouse's estate and poses difficult questions about the desirability and potential for recovering Medicaid costs from the estates of spouses.

However, we would note that the Department has done a great deal to encourage States to initiate estate recovery programs. First, it should be noted that the Health Care Financing Administration (HCFA) has taken a number of actions including:

-- In May 1988, HCFA published a State Agency Successful Practices Guide which includes a chapter on estate recoveries. HCFA profiled five States that have successful programs.

This Guide has been distributed to all single State agency heads, Medicaid Directors, third party liability (TPL) managers, the National Conference of State Legislatures, the National Governors Association, and all HCFA regional offices, among others.

-- We expect this effort to begin to show results in fiscal year (FY) 1989.

-- HCFA has encouraged estate recoveries and use of the Successful Practices Guide in several national meetings this year; e.g. State Medicaid Directors conference and National Conference of State Legislatures.

-- HCFA included estate recoveries in its TPL marketing to selected States in FY 1988.

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-- We plan to take advantage of every appropriate opportunity to encourage States not pursuing estate recoveries, or pursuing them ineffectually, to institute a program and/or take a more aggressive stance.

Secondly, the Office of Inspector General has conducted a comprehensive study on States' estate recovery programs and has provided this information to all Medicaid State agencies. Thirdly, we have developed a departmental task force which is evaluating administrative and regulatory changes to improve States estate recovery programs.

However, in promoting this program, we must keep in mind its political sensitivity. The GAO's recommendations to mandate this program would amend national policy on such fundamental issues as the disposal of the homes of the elderly, the intergenerational transfer of wealth, and the traditional authority of States to set probate policy. For all of these reasons, we would encourage a broad public discussion of these underlying issues.

Finally, we would note that although the basic period of ineligibility governing transfer of homes of institutionalized individuals specified in the statute prior to MCCA was 24 months, this period could have been greater depending upon the net amount of the uncompensated value of the transferred home and the average amount payable under the State plan for care in a nursing facility.

Other Matters

Impact of recent legislative changes and validity of GAO savings estimates.

The recent enactment of the MCCA substantially changed Federal rules in section 1917(c) regarding penalties that States impose on persons who dispose of assets (including the home) for less that fair market value. MCCA made no changes to the authority in section 1917(b) regarding recoveries from the estates of deceased recipients or from the estates of their spouses.

Consequently, GAO's estimates of potential recoveries may no longer be valid; they almost certainly overstate the maximum potential for savings from mandatory estate recovery programs by some amount that should be determined and included in the report. GAO based its estimates on the assumption that each State could perform as effectively as the State of Oregon. Oregon is a relatively small State with approximately $76 million in nursing home expenditures in FY 1985. While additional savings could be expected, we do not believe it is feasible to expect larger States with large Medicaid expenditures to achieve the same percentage of savings.

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Errors in description of legislative history.

The GAO report erroneously traces legislative authority for liens, estate recoveries, and penalties against uncompensated transfers of assets only back to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). In fact, authority for estate recoveries and transfer of assets penalties pre-dates TEFRA.

-- State authority to recover from the estates of deceased recipients existed in the original Medicaid statute enacted in 1965 (P.L. 89-97). All that TEFRA did was move this authority from section 1902(a)(18) to section 1917(b)(1). This raises the difficult question which, it seems to us, would be a reasonable issue for the GAO report to address; i. e., few States have taken full advantage of the authority they have had for over twenty years.

In conclusion, fundamental public policy issues that are embedded in estate recoveries will continue to arise in the long-term care discussions being addressed at the departmental and congressional levels. Discussions will presumably include the interface between traditions of inheritance and repayment of public assistance, Federal requirements vs. State flexibility, and nature and levels of income and resources the individual may exempt and protect. Therefore, we favor a two-pronged approach. First, we would encourage a broad public discussion in Congress and other appropriate forums on the complex underlying issues affecting Medicaid estate recovery programs. Secondly, we would pursue limited legislative, regulatory, and program management change to enhance program effectiveness. HCFA is addressing the program management aspects, and the departmental study, which the GAO mentions in its report, will address the legislative and regulatory aspects.

Comments From the State of California

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 322-5824

November 17, 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General
Accounting Office
Human Resources Division
Washington, DC 20548

Dear Mr. Thompson:

We have been asked to respond to and thank you for your letter of October 21, 1988 to Governor Deukmejian regarding the draft report "Recoveries from Nursing Home Residents' Estates Could Offset Program Costs". This report studied Medicaid nursing home programs in eight states (including California) and has concluded that the States can recover a substantial portion of Medicaid nursing home payments through establishment of effective estate recovery programs. California prides itself as being a leader among Medicaid programs in this endeavor and certainly agrees with this approach. We do not find any discrepancies of data in the references to California.

California's generalized Estate Recovery Program began in 1981 with a collection program of $130,128 and has grown in 7 years to a projected recovery of $25,000,000 for 1988-89 fiscal year.

Hopefully, this report will aid us in implementing some new processes in California. As acknowledged in the study, our State is unable to effect recovery in cases where there is a surviving spouse and/or where the nursing patient received services prior to age 65 due to current State laws and regulations. We are currently preparing enabling State legislation to address these issues. We are also hoping to increase recoveries by providing further training at the county level to clarify the State's authority to file property liens against long term care beneficiaries (at any age) that declare no intent of returning home under current State laws and 42 USC 1396p(a).

Mr. Lawrence H. Thompson
Page 2

If you need further information regarding this matter, please feel free to contact, Gerald B. Rohlfes, Chief, Recovery Branch at (916) 445-0416.

Sincerely,

John Rodriguez
Deputy Director
Medical Care Services

Comments From the State of Michigan

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

JAMES J. BLANCHARD
GOVERNOR

January 10, 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
General Accounting Office
Human Resources Division
Washington, D.C. 29548

Dear Mr. Thompson:

The proposed report to the Secretary of Health and Human Services has been reviewed. Although we do not have specific comments on the contents of the report, the concept certainly may have potential for Michigan.

During the past 10 to 15 years, Michigan has not had a statutory base upon which to subrogate against estates of deceased Medicaid recipients. It is interesting to note how well Oregon has done by enacting legislation specifically authorizing estate recoveries.

Also, with the clarification of federal intent in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Medicare Catastrophic Coverage Act of 1988, it would appear that many states will be addressing the recovery potential.

We, in Michigan, are of the opinion that there is a potential for recovery of some $7 to $9 million dollars after a program is developed and operational.

Based upon the facts and recovery potential, Michigan will be exploring the possibility of implementing such a program.

Sincerely,

JAMES J. BLANCHARD
Governor

Comments From the State of Ohio

Richard F. Celeste
Governor

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

December 13, 1988

United States
General Accounting Office
Human Resource Division
Attention Lawrence H. Thompson
Switzer Building Room 1126
330 C Street SW
Washington D.C. 20201

Dear Mr. Thompson:

On behalf of the Honorable Richard F. Celeste, Governor of Ohio, I am responding to your October 21, 1988 letter concerning the Draft Report "Recoveries From Nursing Home Residents' Estates Could Offset Program Costs".

We substantially agree with the conclusions reached in this report. We agree state recovery programs would increase equity, be cost effective, and would help meet future financial strains on the government's health care effort. We do, however, have some reservations on the amounts projected in the cost benefit analysis. We also foresee that Ohio may have more problems implementing this program than Oregon.

Bill Bogel from the Oregon Department of Human Services' unit in charge of this program stated that part of the reason the program is so successful in Oregon is that the program has been in existence, along with the enabling legislation, for 25 years. This means that advocacy groups in Ohio may have a different perspective on the program than the advocacy groups in Oregon. Also, because Oregon has an established program and Ohio does not, Ohio would face the initial cost associated with the development of the program.

Another advantage that Oregon has is that it is a state administered program which allows them to administer the program from a centralized system. Thus, they are able to send out attorneys from their district offices to impose the liens. This greatly increases their efficiency and provides better control of the program. Ohio has a county administered system which places much of the administrative burden on the local county offices. This may also increases the administrative costs thus reducing the cost benefit ratio.

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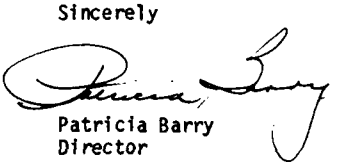
Lawrence H. Thompson
Assistant Comptroller General
Page 2

We do agree that the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) must take a more active leadership role in assisting the states with the development of such programs. In addition HCFA should begin developing a legislative proposal that would provide a more uniform program without the ambiguous language which currently exists as illustrated in Section 1917(b).

Thank you for the Opportunity to respond to your report. If you have any question please feel free to contact my office. Please send us the results of this report along with comments from the other states.

Sincerely



Patricia Barry
Director

PB/dk

cc: Governor Richard F. Celeste

Comments From the State of Oregon

NEIL GOLDSCHMIDT
GOVERNOR

OFFICE OF THE GOVERNOR
STATE CAPITOL
SALEM OREGON 97310 1347

December 5, 1988

Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Thompson:

Thank you for the copy of your report, Recoveries From Nursing Home Residents' Estates Could Offset Program Costs. We are pleased to learn that Oregon's estates program ranks number one nationally for Medicaid estate recoveries.

We project that Medicaid estate recoveries in Oregon for the current biennium will total $10,508,000. Our program aggressively corrects disqualifying transfers of assets, and is active in the preservation of assets so they may be available for the current cost of care as well as the estate. Our goal is to increase estate recoveries while protecting the personal and property rights of the people we serve.

I have attached a comment from the Estate Administration Unit staff for your consideration. We are happy to have been able to provide your office with assistance in preparing the report. Oregon has frequently been called upon to assist other states in implementing Medicaid estate recovery programs. We will continue to provide assistance to other states and anticipate inquiries to increase following the release of your report. We look forward to the challenge of maintaining our national leadership in this area.

Sincerely,

Neil Goldschmidt
Governor

NG:wrl

Enclosure

Comments From the Commonwealth of Pennsylvania

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Harry D. Sewell
Deputy Secretary for Administration

(717) 787-3423

DEC 9 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
441 G Street, Northwest
Room 6864
Washington, D.C. 20548

Re: Review of Medicaid Estate Recovery Programs (GAO/HRD-88-95)

Dear Mr. Thompson:

Since the Department of Public Welfare (Department) is the Single State Agency which administers the Medicaid Program in the Commonwealth of Pennsylvania, Governor Casey has asked the Department to respond to this report on Medicaid Estate Recovery Programs. Secretary White has asked that I respond for the Department.

The Department agrees that there could be increased revenues generated from operating an estate recovery program; however, current Pennsylvania state law does not allow for recovery of properly received benefits. Federal regulations permit recovery of correctly paid Medicaid funds from the estate of an individual who was 65 years of age or older when he or she received Medicaid only:

1) after the death of the individual's surviving spouse, and

2) when the individual has no surviving child who is under age 21, or who is blind or disabled.

If the Commonwealth wants to consider recipients' estates as a source of recovering Medicaid funds, steps would have to be taken to introduce legislation which mandates estate recovery.

We do not necessarily agree with some of the assumptions used to calculate the probable dollar value of an estate recovery program in Pennsylvania. The report data concluded that 8.5 percent of the recipient sample relevant to Pennsylvania owned real property that could be used to help defray the cost of their Medicaid care. They also concluded that the program would have yielded $8.5 million in gross recovery if such a program had been in place affecting the Medicaid nursing home caseload during 1985. Your extrapolations did not totally exclude married nursing home recipients from the dollar projections, but rather assumed that one-half the market

value would subsequently be available from the estate of the spouse living outside the nursing home. We suspect that this assumption is not practical in Pennsylvania, and must conclude that the probable dollars recovered would be less than the $8.5 million.

Although we do not agree with all the information contained in your report, we believe that establishing an estate recovery program in the Commonwealth of Pennsylvania could be a viable option which will be given further consideration by the Department. We do not believe that Medicaid should be forced to carry the burden of providing nursing home care while enlarging the estates of some recipients.

Thank you for giving us the opportunity to respond to this report.

Sincerely,

Harry O. Sewell

cc: Governor Robert P. Casey

Comments From the State of Washington

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

OLYMPIA
98504-0413

BOOTH GARDNER
GOVERNOR

November 10, 1988

United States General Accounting Office
Mr. Lawrence Thompson, Assistant Comptroller General
Human Resources Division
Washington, D.C. 20548

RE: Medicaid Estate Recovery Program

Dear Mr. Thompson:

We have reviewed the proposed report to the Secretary of Health and Human Services on the recent review of Medicaid estate recovery programs.

The state of Washington, Department of Social and Health Services (DSHS), began an Estate Recovery Program with the enactment of legislation in 1987. The scope of the program selected by DSHS was limited to the filing of property liens or creditor claims after the death of medical assistance recipients who were older than 65 years of age. Recovery was further limited in the enacting legislation to estates valued below $50,000, unless there were no close surviving relatives. An amendment to reduce the $50,000 exemption to $35,000 is being proposed for the 1989 legislative session.

It is too soon to assess the overall effectiveness of the DSHS Estate Recovery Program. To date, recoveries are less than originally projected; however, many of the properties involved have not yet been probated or sold. We are confident this will develop into a cost effective program.

Thank you for the opportunity to review and comment on the proposed report.

Sincerely,

Booth Gardner

BOOTH GARDNER
Governor

Comments From the State of Wisconsin

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Tommy G. Thompson
Governor

Patricia A. Goodrich
Secretary

Mailing Address
Post Office Box 7850
Madison WI 53707

November 25, 1988

Lawrence H. Thompson
Assistant Comptroller General
United States General Accounting Office
Human Resources Division
WASHINGTON, D.C. 20548

Dear Mr. Thompson:

Thank you for the opportunity to review and comment on the GAO draft report concerning Medicaid Estate Recovery Programs. The statistical projections contained therein correspond well with the data originally provided by Wisconsin during the research phase of this project. Since providing the GAO with those data, Wisconsin has done considerable research in the area of estate recovery. Due to its outstanding recovery rate, as well as the apparent efficiency with which its program is administered, Oregon's estate recovery program has been studied in detail, as have programs currently operating in several other states. As a result of this study, statutory language has been proposed which would permit Wisconsin to recover Medicaid expenditures from an estate when there is no surviving spouse, minors, or disabled children. Recovery of such monies would be allowed when a home was exempted from consideration as an asset during the eligibility determination process because the institutionalized individual expected to return home. Additionally, recovery would not take place until the home was sold in settlement of the estate.

It is my belief that an estate recovery program, operated with flexibility and a high degree of sensitivity to the needs of the elderly and their families, can accomplish recovery goals without intimidation and confusion. Should you be interested in the details of Wisconsin's proposed estate recovery program, please feel free to contact me. Again, thank you for sharing this report with us.

Sincerely,

Stanley Yorke for
Patricia A. Goodrich
Secretary

Major Contributors to This Report

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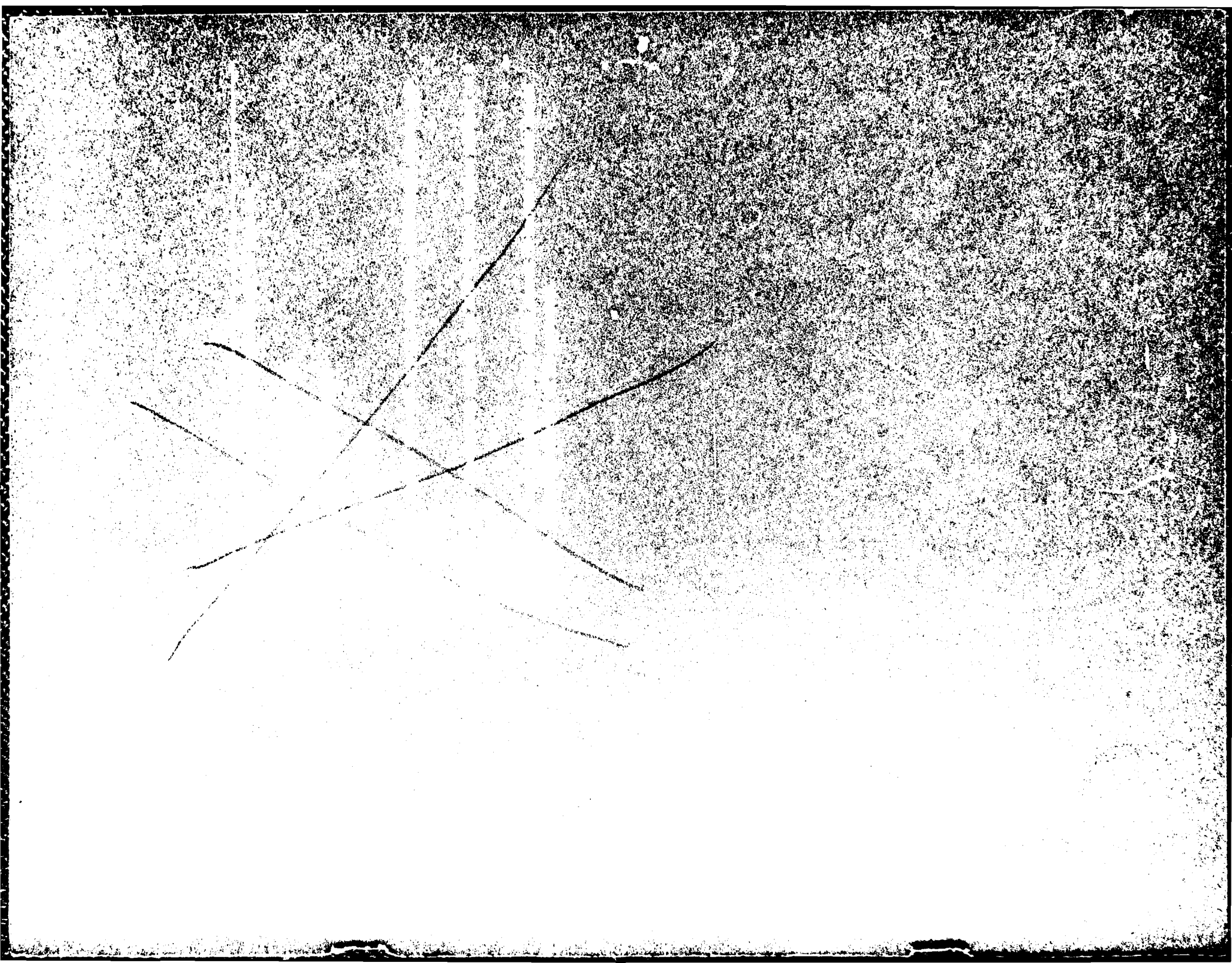

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